

# **Illinois**

## **UNIFORM APPLICATION FY 2009 - STATE PLAN**

### **COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT**

OMB - Approved 08/06/2008 - Expires 08/31/2011

(generated on 9-4-2008 9.03.09 AM)

Center for Mental Health Services  
Division of State and Community Systems Development

## **Introduction:**

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant ( 45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane. Rockville. MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

# Table of Contents

<b>State:</b>
Illinois

<b>Face Page</b>	<b>pg. 4</b>	<b>Adult - Establishment of System of Care</b>	<b>pg. 167</b>
<b>Executive Summary</b>	<b>pg. 5</b>	<b>Adult - Available Services</b>	<b>pg. 187</b>
<b>Certifications</b>	<b>pg. 9</b>	<b>Adult - Estimate of Prevalence</b>	<b>pg. 189</b>
<b>Public Comments on State Plan</b>	<b>pg. 20</b>	<b>Adult - Quantitative Targets</b>	<b>pg. 191</b>
<b>Set-Aside For Children Report</b>	<b>pg. 22</b>	<b>Adult - Outreach to Homeless</b>	<b>pg. 194</b>
<b>MOE Report</b>	<b>pg. 23</b>	<b>Adult - Rural Area Services</b>	<b>pg. 199</b>
<b>Council List</b>	<b>pg. 25</b>	<b>Adult - Older Adults</b>	<b>pg. 202</b>
<b>Council Composition</b>	<b>pg. 37</b>	<b>Adult - Resources for Providers</b>	<b>pg. 205</b>
<b>Planning Council Charge, Role and Activities</b>	<b>pg. 38</b>	<b>Adult - Emergency Service Provider Training</b>	<b>pg. 209</b>
<b>Adult - Overview of State's Mental Health System</b>	<b>pg. 50</b>	<b>Adult - Grant Expenditure Manner</b>	<b>pg. 213</b>
<b>Adult - Summary of Areas Previously Identified by State as Needing Attention</b>	<b>pg. 53</b>	<b>Table C - MHBG Transformation Expenditures Reporting Form</b>	<b>pg. 215</b>
<b>Adult - New Developments and Issues</b>	<b>pg. 55</b>	<b>Table C - Description of Transformation</b>	<b>pg. 216</b>
<b>Adult - Legislative Initiatives and Changes</b>	<b>pg. 62</b>	<b>Adult - Goals Targets and Action Plans</b>	<b>pg. 230</b>
<b>Adult - Description of Regional Resources</b>	<b>pg. 66</b>	<b>Child - Establishment of System of Care</b>	<b>pg. 257</b>
<b>Adult - Description of State Agency's Leadership</b>	<b>pg. 68</b>	<b>Child - Available Services</b>	<b>pg. 265</b>
<b>Child - Overview of State's Mental Health System</b>	<b>pg. 77</b>	<b>Child - Estimate of Prevalence</b>	<b>pg. 267</b>
<b>Child - Summary of Areas Previously Identified by State as Needing Attention</b>	<b>pg. 79</b>	<b>Child - Quantitative Targets</b>	<b>pg. 269</b>
<b>Child - New Developments and Issues</b>	<b>pg. 81</b>	<b>Child - System of Integrated Services</b>	<b>pg. 272</b>
<b>Child - Legislative Initiatives and Changes</b>	<b>pg. 83</b>	<b>Child - Geographic Area Definition</b>	<b>pg. 282</b>
<b>Child - Description of Regional Resources</b>	<b>pg. 85</b>	<b>Child - Outreach to Homeless</b>	<b>pg. 284</b>
<b>Child - Description of State Agency's Leadership</b>	<b>pg. 87</b>	<b>Child - Rural Area Services</b>	<b>pg. 286</b>
<b>Adult - Service System's Strengths and Weaknesses</b>	<b>pg. 89</b>	<b>Child - Resources for Providers</b>	<b>pg. 289</b>
<b>Adult - Unmet Service Needs</b>	<b>pg. 117</b>	<b>Child - Emergency Service Provider Training</b>	<b>pg. 291</b>
<b>Adult - Plans to Address Unmet Needs</b>	<b>pg. 119</b>	<b>Child - Grant Expenditure Manner</b>	<b>pg. 293</b>
<b>Adult - Recent Significant Achievements</b>	<b>pg. 122</b>	<b>Child - Goals Targets and Action Plans</b>	<b>pg. 295</b>
<b>Adult - State's Vision for the Future</b>	<b>pg. 127</b>	<b>Planning Council Letter for the Plan</b>	<b>pg. 316</b>
<b>Child - Service System's Strengths and Weaknesses</b>	<b>pg. 129</b>	<b>Appendix A (Optional)</b>	<b>pg. 320</b>
<b>Child - Unmet Service Needs</b>	<b>pg. 158</b>		
<b>Child - Plans to Address Unmet Needs</b>	<b>pg. 160</b>		
<b>Child - Recent Significant Achievements</b>	<b>pg. 163</b>		
<b>Child - State's Vision for the Future</b>	<b>pg. 165</b>		

**FACE SHEET**  
**FISCAL YEAR/S COVERED BY THE PLAN**  
**X FY2009          FY 2009-2010          FY 2009-2011**

STATE NAME: Illinois

DUNS #: 6919071

**I. AGENCY TO RECEIVE GRANT**

AGENCY: Illinois Department of Human Services

ORGANIZATIONAL UNIT: Division of Mental Health

STREET ADDRESS: 160 North LaSalle Street, 10th Floor

CITY: Chicago

STATE: IL

ZIP: 60601

TELEPHONE: 312-814-4948

FAX: 312-814-2964

**II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR  
ADMINISTRATION OF THE GRANT**

NAME: Carol L. Adams, Ph.D TITLE: Secretary

AGENCY: Illinois Department of Human Services

ORGANIZATIONAL UNIT:

STREET ADDRESS: 401 South Clinton Street

CITY: Chicago

STATE: IL

ZIP CODE: 60601

TELEPHONE: 312-793-1533

FAX:

**III. STATE FISCAL YEAR**

FROM: 07/01/2008 TO: 06/30/2009

**IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION**

NAME: Mary E. Smith, Ph.D. TITLE: Associate Director, Decision Support, Research and Evaluation

AGENCY: Illinois Department of Human Services

ORGANIZATIONAL UNIT: Division of Mental Health

STREET ADDRESS: 160 Noeth LaSalle Street, 10th Floor

CITY: Chicago

STATE: IL

ZIP: 60601

TELEPHONE: 312-814-4948

FAX: 312-814-2964

EMAIL: MaryE.Smith@illinois.gov

# Illinois

## Executive Summary

Please respond by writing an Executive Summary of your current year's application.

## **FY 2009 MENTAL HEALTH BLOCK GRANT APPLICATION EXECUTIVE SUMMARY**

---

The Illinois Department of Human Services-Division of Mental Health (DMH) is responsible for managing and purchasing a comprehensive array of services that provide effective treatments to people most in need of publicly funded mental health care. The policies and practices of the DMH focus on fostering coordination and integration of services provided by DMH funded community agencies, private hospitals, and state hospitals across Illinois. A range of collaborative initiatives increase coordination with other state agencies whose services are accessed by individuals receiving mental health services. The FY2009 Mental Health Block Grant Plan reflects these coordination efforts as well as an emphasis on developing and directing care which is consumer and family driven. DMH is actively continuing to transform the mental health service delivery system in Illinois to one that is recovery-oriented. These efforts include increasing consumer and family involvement in planning and implementation activities, expanding the focus on planning and implementation of evidenced-based practices, and continued planning for the transition to a fee-for-service system from a primarily grant-based funding system. A wide array of stakeholders representing consumers, family members of individuals with mental illnesses, advocates and public service agencies purchasing or providing treatment to individuals with mental illnesses participate in these efforts. The anticipated outcome is the continued enhancement of activities that support the recovery-orientation of the mental health system and address the needs of consumers and their families.

There continue to be significant fiscal challenges to the mental health service system in FY 2009. Illinois, like many other states, experienced a serious economic downturn that began in 2001. Although there has not been an increase in funding, the Division has worked diligently to increase revenue from Medicaid and to seek grant funding to support programmatic efforts.

During FY 2009, the efforts of the DMH remain focused on: (1) planning efforts to continue transformation of the Illinois Mental Health service delivery system, (2) sustaining the significant accomplishments of recent years, (3) continuing the development of the public mental health service system through joint planning, coordination and implementation efforts, (4) emphasizing consumer education, recovery-orientation and enhanced consumer and family involvement in planning and evaluation activities, and (5) continuing development and initiation of strategies to expand access to evidence-based practices. The format of this FY 2009 plan reflects these themes, and is synchronized with the overall planning process of the DMH.

### **Plan Organization**

As the Illinois Mental Health Authority, the DMH is responsible for public mental health services for both children and adults. The presentation of the FY2009 plan reflects this service integration and is organized in compliance with the SAMHSA CMHS format which calls for two separate plans---one for adults and one for children. This organization is reflected in the Narrative, as well as in the performance indicators that relate to the

plan. To reduce redundancy, where there are sections of narrative applicable to both adults and children these are in the Adult Plan and referenced in the Child plan. When different sections of the same plan cover the same subject, references are made to the section that has the more complete presentation of the material.

The following are highlights of this year's application and plan:

- A new **permanent supportive housing initiative** which has been designed to accommodate at least 150 consumers in FY2009 and 450 more consumers in the next two years that may be expanded with additional funding.
- A procurement process for an **Administrative Services Organization (ASO)** led to the selection, in Fall, 2007, of a national behavioral health company to assist DHS/DMH in implementing a number of contractual objectives. The ASO, called the Illinois Mental Health Collaborative for Access and Choice (MHCAC), has been operational since December, 2007 and the assistance provided by the MHCAC encompasses a broad spectrum of administrative activity.
- **Say It Out Loud** is a groundbreaking new statewide public awareness campaign launched in May, 2008 to promote mental health by presenting accurate and positive representations about mental illness and diminishing the barriers that prevent people from seeking or offering help and support. It is co-sponsored by IDHS/DMH and the Illinois Children's Mental Health Partnership.
- DMH, working with the Mental Health Collaborative for Access and Choice (MHCAC), has **redesigned the management information system (MIS)** to include a data warehouse that will house eligibility, registration, billing/services information, a provider database, and service authorization in one place and updating key clinical and demographic fields that will be used to track consumer outcomes over time.
- Access to the new **Certified Recovery Support Specialist** (CRSS) credential became available through the Illinois Certification Board (ICB) beginning in July of 2007. Individuals are certified as having met specific predetermined criteria for essential competencies and skills and are recognized for their ability to provide quality services.
- A statewide mental health/criminal justice needs assessment and system mapping initiative funded by a **SAMHSA Transformation Transfer Initiative** grant that is helping to inform the system transformation process in Illinois.
- This year, DMH funded child serving agencies will be able to participate in the newly-established **web-based Clinical Outcomes Analysis System** from which reports showing data trends in service outcomes can be generated for feedback to clients and families, providers, and to DMH.C&A Services.
- An **education and training initiative for mental health providers .in support**

**of mental health trauma** work with children and families who have experienced trauma as a result of physical abuse, neglect, sexual abuse or domestic violence that has an effect on their behavior, performance and adjustment.

- Use of block grant dollars to promote **consumer-to-consumer outreach** and mentoring.
- The continuing investment of block grant dollars to increase and improve **psychiatric leadership and services**.
- Enhancing mental health services for children and adolescents through a range of pilot projects in services to **transitioning youth, tele-psychiatry in rural areas, early intervention, early childhood services**, and consultation on early childhood development and clinical intervention.
- Continuing to develop strategies to increase access to **evidence-based practices**.
- Establishing linkages with **jails, juvenile detention facilities, and the Courts** to serve adjudicated consumers.
- Providing training and consultation to community-based staff serving children and adolescents in **Evidence-Informed Practices**.
- Working collaboratively in consultation with schools to **expand early intervention and prevention** in mental health.
- Initiatives for elderly persons in **rural areas** that are aimed at providing consultation and promoting the integration of mental health services in meeting the needs of **older adults**.

### **Mental Health System Performance Indicators**

The FY2009 plan contains Illinois-specific performance indicators, as well as indicators relating to the SAMHSA CMHS National Outcome Measures (NOMS). The system performance indicators are described in a separate section of each plan and clearly referenced in the plan narrative so that the reader may cross-reference them, or simply review them as a set. The Illinois specific indicators are used to monitor the impact of the mental health services that are purchased on behalf of mental health consumers. These indicators include information that is collected and reported as part of the CMHS Uniform Reporting System. This ability to track values of indicators across time has assisted in identifying issues that need to be addressed within the public mental health service system and have served as a basis for planning. Additional indicators are added as required to meet the priorities of mental health system development.

## **Attachment A**

### **COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS**

FISCAL YEAR 2009

I hereby certify that Illinois agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

#### **Section 1911:**

Subject to Section 1916, the State<sup>1</sup> will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

#### **Section 1912**

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms adults with a serious mental illness and children with a severe emotional disturbance and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

#### **Section 1913:**

(a)(1)(C) In the case for a grant for fiscal year 2008, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

---

21. The term State shall hereafter be understood to include Territories.

(C)(1) With respect to mental health services, the centers provide services as follows:

- (A) Services principally to individuals residing in a defined geographic area (referred to as a service area )
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

#### **Section 1914:**

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

- (A) the principle State agencies with respect to:
  - (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
  - (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
- (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
- (D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
- (B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

**Section 1915:**

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

**Section 1916:**

(a) The State agrees that it will not expend the grant:

- (1) to provide inpatient services;
- (2) to make cash payments to intended recipients of health services;
- (3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- (4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
- (5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

**Section 1941:**

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

**Section 1942:**

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and  
(2) the recipients of amounts provided in the grant.

- (b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
- (c) The State will:
- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
  - (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

### **Section 1943:**

- (a) The State will:
- (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
    - (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
    - (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
    - (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section
- (b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

---



Carol L. Adams, Ph.D, Secretary, Illinois Dept of Human Services

Date

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace;
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

- point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
- (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
 Office of Grants Management  
 Office of the Assistant Secretary for Management and Budget  
 Department of Health and Human Services  
 200 Independence Avenue, S.W., Room 517-D  
 Washington, D.C. 20201

### **3. CERTIFICATION REGARDING LOBBYING**

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### **4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

## 5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary, Department of Human Services
APPLICANT ORGANIZATION Illinois Department of Human Services/Division of Mental Health	DATE SUBMITTED

# DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB  
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352  
(See reverse for public burden disclosure.)

<b>1. Type of Federal Action:</b> <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. Status of Federal Action</b> <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. Report Type:</b> <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change  <b>For Material Change Only:</b> Year _____ Quarter _____ date of last report _____
<b>4. Name and Address of Reporting Entity:</b>  Prime Subawardee  Tier _____, if known:		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>
<b>Congressional District, if known:</b>		<b>Congressional District, if known:</b>
<b>6. Federal Department/Agency:</b>		<b>7. Federal Program Name/Description:</b>  CFDA Number, if applicable: _____
<b>8. Federal Action Number, if known:</b>		<b>9. Award Amount, if known:</b> \$ _____
<b>10. a. Name and Address of Lobbying Entity</b> <i>(if individual, last name, first name, MI):</i>		<b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>
<b>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</b>		Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____
<b>Federal Use Only:</b>		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

## **INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES**

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
- 10.(a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.  
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET.  
SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Secretary, Department of Human Services	
APPLICANT ORGANIZATION Illinois Department of Human Services/Division of Mental Health	DATE SUBMITTED	

# Illinois

## Public Comments on State Plan

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

The development of the state mental health block grant plan is made available for public comment in several ways. (1) The Illinois Mental Health Planning and Advisory Council (MHPAC) includes consumers of mental health services and family members who also participate in a range of advocacy groups such as the Mental Health Summit, the Mental Health Association and the Illinois Alliance for the Mentally Ill. Council members regularly consult with their respective advocacy groups during the development of the state plan. (2) All Council meetings are open to the public. Council meeting dates are set up a year in advance to facilitate participation. Persons with an interest in the state plan may attend meeting at which the plan is discussed and provide feedback and comments. (3) The FY 2008 block grant plan was reviewed by the Planning Committee for the Illinois MHPAC during its development on several occasions. A formal meeting to review the plan was held on August 2nd. The Block Plan has also been discussed at all MHPAC meetings in the past year. Notice of the availability of the plan via the web was emailed to all Council members. (4) The final state block grant application and proposed plan will be posted on the web site for the Division of Mental Health ([www.dhs.state.il.us](http://www.dhs.state.il.us)) by September 12, 2007. The public can access this DHS DMH Internet site. Interested parties have been instructed to contact Dr. Mary E. Smith to provide comment. Contact information is provided on the website.

## **II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT**

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

### **Data Reported by:**

**State FY X                          Federal FY \_\_\_\_\_**

### **State Expenditures for Mental Health Services**

<b>Calculated FY 1994</b>	<b>Actual FY 2007</b>	<b>Estimate/Actual FY 2008</b>
<b><u>\$24,236,971</u></b>	<b><u>\$84,822,489</u></b>	<b><u>\$89,838,188</u></b>

### **Waiver of Children's Mental Health Services**

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

### **III. MAINTENANCE OF EFFORT(MOE) REPORT**

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

#### **MOE Exclusion**

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

#### **MOE information reported by:**

**State FY X**

**Federal FY \_\_\_\_\_**

#### **State Expenditures for Mental Health Services**

<b>Actual FY 2006</b>	<b>Actual FY 2007</b>	<b>Actual/Estimate FY 2008</b>
<b>\$414,287,972</b>	<b>\$428,645,083</b>	<b>\$431,292,309</b>

## **MOE Shortfalls**

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

### (1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

### (2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

**TABLE 1.** List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Anselmo, Frank	Others(not state employees or providers)	Community Behavioral Health Assn	3085 Stevenson Drive Springfield,IL 62703 PH:217-585-1600 FAX:	fanselmo@cbha.net
Ayres, Cassie	Others(not state employees or providers)	Illinois Association of Rehabilitation Facilities	206 South Sixth Street Springfield,IL 62701 PH:217-753-1190 FAX:217-525-1271	cayres@hso.net
Barnes, Kimberly	Family Members of Children with SED		P.O. Box 185 Shawneetown,IL 62984 PH:618-269-3670 FAX:	
Boyd, Cheryl	Providers	Franklin-Williamson Human Services	Franklin Williamson Human Services 902 West Main Street West Frankfort,IL 62896 PH:618-937-6483 FAX:618-937-1440	Cheryl.Boyd@whs.org
Burchell, Juana	State Employees	Education	100 North 1st Street Springfield,IL 62777 PH:217-782-5589 FAX:	jburchel@isbe.net
Buss, Donna	Consumers/Survivors/Ex-patients(C/S/X)		620 Dakota Street Crystal Lake,IL 60012 PH:815-354-1577 FAX:815-	dbuss@mc708.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
			455-2925	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Connor, Ray	Family Members of Children with SED		3 Creekside Lane Barrington,IL 60010 PH:847-426-3692 FAX:847-649-8915	rayconner@comcast.net
Cooke, Andrea	Consumers/Survivors/Ex-patients(C/S/X)		3061 Euclid Lane Richton park,IL PH:788-288-4550 FAX:	a-cooke@sbcglobal.net
Daxenbichler, Cindy	Family Members of Children with SED		1301 Sommerset Street Pekin,IL 61554 PH:309-642-1080 FAX:	Taurus463@insightbb.com
Day, John	Providers	Mental Health Assn of Illinois	3716 West Brighton Peoria,IL 61615 PH:309-691-7755 FAX:888-448-0240	drjrdy@juno.com
Denson, Linda	Consumers/Survivors/Ex-patients(C/S/X)	Sankofa Organization of Il	7619 Parnell Avenue Chicago,IL 60660 PH:312-636-4051 FAX:773-651-4882	ldsankofail@aol.com
Durkin, Eileen	Providers	Victor C Newmann Assn	5547 North Ravenswood Chicago,IL 60640 PH:773-506-3024 FAX:773-907-5501	eild@aol.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Ford-Whitsett Smith, Pamela	Consumers/Survivors/Ex-patients(C/S/X)	Bobby E. Wright Behavioral Health Center	9 south Kedzie Chicago,IL 60612 PH:773-722-7900 FAX:773-722-0644	
Frazier, Sondra	Family Members of Children with SED		6957 South Jeffrey Blvd Chicago,IL 60649 PH:773-324-6644 FAX:	lasalf@aol;.com
Friedman, Fred	Consumers/Survivors/Ex-patients(C/S/X)		6513 North Sacramento Chicago,IL 60645 PH:773-274-2150 FAX:	frd@nextstepsnfp.org
Hanko, Stephanie	State Employees	Medicaid	607 E. Adams Street (covers Social Srvs) 4th floor Springfield,IL 62701 PH:217-557-1031 FAX:217-557-7062	Stephanie.A.Hanko@Illinois.gov
Heyrman, Mark	Others(not state employees or providers)	University of Chicago	6020 South University Avenue Chicago,IL 60637 PH:773-753-4440 FAX:773-702-2063	m-heyrman@uchicago.edu
Hopkins, Dennis	Providers	Iroquois Mental Health Center	323 West Mulberry Street Watseka,IL 60970 PH:815-432-5241 FAX:	dhopkins@imhc.net

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Irving, Anne	Others(not state employees or providers)	AFSCME	29 North Wacker Drive, Suite 800 Chicago, IL 60601 PH:312-641-6060 FAX:312-346-1016	annei@afscmeillinois.org
James, Brian	Consumers/Survivors/Ex-patients(C/S/X)		210 Avenue C Danville, IL 61832 PH: FAX:	
Knaebe, Diana	Providers	Heritage Behavioral Health Center	P.O. Box 710 151 North Main Street Decatur, IL 62525 PH:217-420-4702 FAX:217-362-6290	dknaebe@heritagenet.org
Koeliker, Marsha	Others(not state employees or providers)	Equip for Equality	20 North Michigan Avenue, Suite 300 Chicago, IL 60602 PH: FAX:	marsha@equipforequality.org
Kolar, Antar	Consumers/Survivors/Ex-patients(C/S/X)		211 Elgin - Apt. 6J Forest Park, IL 60130 PH:708-771-0472 FAX:	
Kopera, Anthony	Providers	Community Counseling Centers of Chicago	4740 North Clark Street Chicago, IL 60640 PH:773-769-0205 FAX:	tony.kopera@c4chicago.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Lake, Virginia	Consumers/Survivors/Ex-patients(C/S/X)	Thresholds	202 North Schuyler Avenue - Suite 205 Kankakee, IL 60901 PH:815-935-8886 FAX:	vlake@thresholds.org
Larson, Nanette	Consumers/Survivors/Ex-patients(C/S/X)	State Rep - Consumer Affairs	5407 North University Street Chicago, IL 61614 PH:309-693-5228 FAX:	Nanette.Larson@illinois.gov
Lindahl, Teri	Family Members of Children with SED	McHenry County Mental Health Board	620 Dakota Street Crystal Lake, IL 60012 PH:815-455-2828 FAX:815-455-2829	tlindahl@mc708.org
Martinez, MD, Daniel B	Providers	Lutheran Social Services - Child Psychiatrist	4840 West Byron Street Chicago, IL 60641 PH:773-282-7800 FAX:	Db_martinez@yahoo.com
May, Jann	Consumers/Survivors/Ex-patients(C/S/X)	Community Counseling Center	2615 Edwards Street Alton, IL 62002 PH:618-462-2331 FAX:	
Moffett, Regina	Consumers/Survivors/Ex-patients(C/S/X)		661 East 69th Street, Unit 607 Chicago, IL 60637 PH: FAX:	Mzreginam2003@yahoo.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Nance, Mike	Consumers/Survivors/Ex-patients(C/S/X)	Heritage Grove	365 East Waggoner St Decatur,IL 62526 PH: FAX:	Mnance1284@yahoo.com
Navarro, Wendy	State Employees	Criminal Justice	30W200 Ferry Road Warrenville,IL 60555 PH:815-284-6611 FAX:	wnavarro@idoc.state.il
Nehrborn, Caryn	Consumers/Survivors/Ex-patients(C/S/X)		1126 Healthcare Drive, Unit 104 Mt. Carroll,IL 61053 PH:815-284-6611 FAX:	
Nolen, Kim	Family Members of Children with SED		1753 186th Place Homewood,IL 60430 PH:708-798-2820 FAX:	knolen@sbcglobal.net
Novak, Psy.D, Joseph	Providers	North West Community Hospital	800 West Central Road Arlington Heights,IL 60005 PH:847-618-4075 FAX:	jnovak@nch.org
O'Shea, Lynn	Providers	Association for Individual Development	309 West New Indian Trail Court Aurora,IL 60506 PH:630-966-4001 FAX:630-844-9884	loshea@the-association.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Oulvey, Gene	State Employees	Vocational Rehabilitation	618 E Washington, 3rd Floor Springfield, IL 62794 PH:217-785-7636 FAX:217-524-7549	Gene.Oulvey@illinois.gov
Pannell, Wende	Family Members of Children with SED		733 N May Aurora, IL 60506 PH:630-801-1669 FAX:	Brotn9@aol.com
Patterson, Jerry	Consumers/Survivors/Ex-patients(C/S/X)	Traditions NFP	805 19th Street Rock Island, IL 61201 PH:309-793-4993 FAX:	jpatterson@transrehab.org
Peterson, Anne	Consumers/Survivors/Ex-patients(C/S/X)		226 Lincoln Parkway Crystal Lake , IL 60014 PH:815-455-1391 FAX:	
Pluta, William	State Employees	Housing	Illinois Housing Development Authority 401 North Michigan Avenue, suite 900 Chicago, IL 60611 PH:312-836-5354 FAX:312-832-2191	wpluta@ihda.org
Schneider, Beth	Consumers/Survivors/Ex-patients(C/S/X)		444 West Frontage Road Northfield, IL 60076 PH:847-501-4718 FAX:	bschneider@wilpower.org

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Shustitzly, John	Providers	Pillars	333 North LaGrange Road LaGrange Park, IL 60526 PH:708-698-5500 FAX:	jshustitzky@pillarscommunity.org
Sorrells, Anita	Family Members of Children with SED		2009 Windsor Street Pekin, IL 61554 PH:309-346-1643 FAX:	anitasorrels@insightbb.com
St.Clair, Cathy	Consumers/Survivors/Ex-patients(C/S/X)		6301 North Sheridan Road #8D Chicago ,IL 60660 PH:312-630-0278 FAX:	cstclair@centerforprogress.org
Thomas, Lisa	Family Members of Children with SED		1775 Kings Gate Lane Crystal Lake, IL 60014 PH:815-455-5396 FAX:	
Troe, Thomas	Consumers/Survivors/Ex-patients(C/S/X)		8421 Nortj Selkirk Peoria, IL 61615 PH:309-966-1223 FAX:	t.troe@comcast.net
Virgil, Linda	Family Members of adults with SMI		1434 Greendell Decatur, IL 62562 PH:217-877-1569 FAX:	

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Vyverberg, Robert Ed.D.	State Employees	Mental Health	5407 North University Peoria,IL 61614 PH:309-693-5228 FAX:	Robert.Vyverberg@illinois.gov
Ware, Frank	Providers	Janet Wattles Mental Health Center	526 West State Street Rockford,IL 61101 PH:815-968-9300 FAX:	fware@janetwattles.org
Weissman, Sidney MD	State Employees	Other	676 St. Clair, Suite 1760 Chicago,IL 60611 PH: FAX:	Sidney.Weissman@med.va.gov
Wells, Don P	Consumers/Survivors/Ex-patients(C/S/X)		9524 Robinson Lane Mapleton,IL 61547 PH:309-697-0090 FAX:	Don.Wells@illinois.gov
Zych, Gilbert	Providers	Lyons Township Mental Health Commission	6404 Joliet Road Countryside,IL 60525 PH:708-352-2992 FAX:708-354-7212	ltmhc@lyonsts.com

**TABLE 2. Planning Council Composition by Type of Member**

Type of Membership	Number	Percentage of Total Membership
<b>TOTAL MEMBERSHIP</b>	53	
Consumers/Survivors/Ex-patients(C/S/X)	19	
Family Members of Children with SED	9	
Family Members of adults with SMI	1	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	5	
<b>TOTAL C/S/X, Family Members and Others</b>	34	64.15%
State Employees	7	
Providers	12	
Vacancies	0	
<b>TOTAL State Employees and Providers</b>	19	35.85%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

# Illinois

## Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems, monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.

the role of the Planning Council in improving mental health services within the State.

<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

## **PART B – ADMINISTRATIVE REQUIREMENTS, FISCAL PLANNING ASSUMPTIONS AND SPECIAL GUIDANCE**

### **IV. State Mental Health Planning Councils**

- 1. The IMHPAC bylaws include the role and purpose of the Council as well as the membership requirements.**

#### **By-Laws of the Illinois Mental Health Planning and Advisory Council (IMHPAC)**

##### **ARTICLE I - NAME**

The name of this unincorporated association shall be the Illinois Mental Health Planning and Advisory Council (the “Council”).

##### **ARTICLE II - PURPOSE**

The purposes of the Council shall be: (1) to exchange information and develop, evaluate and communicate ideas about mental health planning, (2) to review and make recommendations regarding the Federal Mental Health Services Block Grant plan for mental health services in the State of Illinois, (3) to advise the Illinois Department of Human Services Division of Mental Health and other departments, divisions and agencies of state government concerning proposed and adopted plans affecting mental health services provided or coordinated by the state and the implementation thereof, (4) to monitor, review and evaluate the allocation and adequacy of mental health services in Illinois and to advise the Illinois state government concerning the need for and quality of services and programs for adults with mental illness and children and adolescents with serious emotional disturbances, and (5) to develop and take advocacy positions concerning legislation and regulations affecting mental health.

##### **ARTICLE III - MEMBERSHIP**

###### **Section 1.     Qualifications**

Council membership composition shall follow the guidelines set forth in P.L. 102-321 and any subsequent federal regulation. The Council shall have at least 45 and no more than 55 members. Less than 50% of the members shall be state employees or employed by any entity which provides mental health services.

###### **Section 2.     Election of Members**

(a) No later than October 1st of each year, the Council Development Committee shall notify the Council in writing of the names of Council members whose terms will expire on December 31st. This notice shall include the geographic location of each Council member whose term will expire, whether that member represents a service provider, persons with a mental illness, family members of persons with mental illness, family members of children or adolescents with a serious emotional disturbance or a specific state agency. The Committee shall solicit nominees from the Council, mental health service providers and organizations representing service providers, organizations which represent or are advocates for persons with mental illness or their relatives.

(b) The Committee shall request that the Division of Mental Health designate a representative to be a member of the Council and that the Division of Mental Health solicit representatives from the Division of Rehabilitation Services, the Department of Corrections, the Housing Development Authority, the Department of Public Aid, and the State Board of Education. The Committee shall request that a union representing persons employed by the Division of Mental Health shall designate a representative.

(c) The Committee shall nominate a slate of proposed new members to be elected during the Fall meeting of the Council. Such slate shall include the persons designated pursuant to paragraph (b) of this Section. The Committee shall ensure that the slate and the membership of the Council as a whole are comprised in a manner so that:

- (i) members are chosen in compliance with all applicable federal laws and regulations and these bylaws;
- (ii)each region of the state is adequately represented;
- (iii) the ratio of parents of children and adolescents with serious emotional disturbances to the other members of the Council is sufficient to provide adequate representation to such parents; and,
- (iv) there is diversity in the racial, gender, ethnic and geographic composition of the Council as a whole.

(d) The Council shall vote for the entire slate of proposed new members as a group. Any member of the Council may by motion propose an alternative slate of new members provided such slate complies with the provisions in subsection (c) of this Section and provided such motion is seconded by a member of the Council. The members of the slate which receives the most votes shall be considered elected to the Council.

(e) The Committee may appoint a new member when, during the course of any year, a vacancy occurs. Whenever one or more new members are appointed by the Committee, the Committee shall promptly advise the full Council in writing of the appointment.

### Section 3. Terms

Members shall be elected to serve a three-year term. No member shall serve more than three consecutive terms. However, there shall be no limit to the number of terms served by a representative chosen by the Division of Mental Health, the Division of Rehabilitation Services, the Department of Corrections, the Housing Development Authority, the Department of Public Aid , the State Board of Education or a union representing persons employed by the Division-Office of Mental Health.

### Section 4. Compensation

The members of the Council shall serve without pay, but the Council may authorize or recommend the payment of reasonable and necessary expenses incurred by the members in the performance of their duties. By vote of the Council in which consumers shall not participate, the Council may authorize compensation for consumers for their participation in the work of the Council and its committees to the extent that such consumers are not otherwise compensated for this work.

### Section 5. Removal of Members

A member may be removed by the Council whenever in its judgment the best interests of the Council would be served thereby. Whenever a member has failed to attend at least 50% of the regularly scheduled meetings in any calendar year, the Council Development Committee shall notify the Council and the member of that fact. If the committee determines that good cause does not exist for the failure of the member to attend Council meetings, the Committee shall move that the member be removed. Removal may occur only at a properly called meeting of the Council, after at least thirty days written notice to the person proposed to be removed and to the Council. No member may be removed unless at least two thirds of the members present vote to remove a member. Any member may resign at any time by giving written notice to the Council.

## **ARTICLE IV--MEETINGS**

### Section 1. Timing and location

Regular meetings of the Council shall be held at least four times each year. The dates of the regular meetings shall be determined at the beginning of each year and a written schedule of the meetings shall be provided to each member. The Council may decide to meet more frequently. At least two meetings each year shall be held in Cook County and at least two meetings each years shall be held in Sangamon County. Special meetings of the Council may be called at any time by the co-chairs or by a written request to either of the co-chairs from 25% of the members. Members may participate in Council meetings through video-conferencing or other similar technologies if such technologies are available.

### Section 2. Notice

The co-chairs may call for a special meeting of the Council by mailing an agenda to all of the members at least 7 days prior to any such meeting, and not more than 60 days prior to any such meeting.

Section 3. Quorum

A quorum of the Council shall exist if one third or more of the total members as of the day prior to the meeting are present. A majority of the members present is required for any action of the Council.

Section 4. Powers

The Council shall have all of the powers vested in it by virtue of these Bylaws, together with any other reasonable and necessary powers to carry out the purposes of the Council. The Council may commit the Council, but not the State of Illinois or the Division of Mental Health or any member, concerning any matter within the purpose of the Council.

Section 5. Open Meetings

All meetings of the Council shall be open to the public. The Council shall take reasonable steps to insure that persons and organizations with an interest in the mental health system in Illinois are notified of the time and location of all meetings, including, if possible listing such meetings on the websites of relevant government agencies. A reasonable period shall be set aside at all meetings of the Council for members of the public to address the Council. Members of the public shall be permitted to propose "new business" for the next meeting of the Council. Subject to veto by the Council, such new business shall be placed on the next Council meeting agenda.

Section 6. Alternates; Abstention

There shall be no proxies for meetings of the Council. A member of the Council may designate an alternative to attend Council meetings when such member is unable to attend, but such an alternative shall not be entitled to vote.

Section 7. Rules of Order

In all procedural matters not governed by these Bylaws, the Council shall be bound by the provisions of *Robert's Rules of Order, Newly Revised* (1990). But the Council may, by the vote of two-thirds of a quorum of the Council present at a meeting of the Council, suspend any provision of these Bylaws or of *Robert's Rules*, at any time, whether or not such suspension is on the agenda.

Section 8. Participation of the Division of Mental Health/Youth and Geriatric Advisory Councils

The co-chairs of the Council shall request that the Division of Mental Health designate such representatives as may be appropriate to attend meetings of the Council and its committees. Whenever issues relating to the delivery of mental health services to aged persons or to children or adolescents are to be discussed, the Division of Mental Health shall take reasonable steps to obtain the presence at Council meetings of one or more members of the Geriatric Advisory Council or Youth Advisory Council as it deems appropriate.

## **ARTICLE V - OFFICERS**

### Section 1. Terms

The officers of the Council shall consist of one co-chair who is a service provider, one co-chair who is a primary or secondary consumer, a secretary and a treasurer. Each officer shall serve for two years unless such person ceases to be qualified to serve as an officer. Each officer shall hold office until his or her successor shall have been duly elected by the Council.

### Section 2. Nominations

The Council Development Committee shall solicit nominations for officer positions from the Council and from the Division of Mental Health. The Committee shall choose at least one person for each office. Nominees receiving a plurality vote of the Committee for the available vacancies shall be declared elected. Each position shall be voted on separately.

### Section 3. Duties of Co-Chairs

The co-chairs shall be the parliamentary chairs of the Council. It shall be the duty of the co-chairs to preside over all meetings of the Council, and, subject to the control of the Council, to supervise and control all of the business affairs of the Council. The co-chairs shall be *ex-officio* members of all committees. The co-chairs shall see that all motions and resolutions of the Council are carried into effect.

### Section 4. Duties of Treasurer

The Treasurer shall be responsible for accounting for any funds allocated or obtained for the use of the Council, subject to the oversight of the Finance Committee.

### Section 5. Duties of Secretary

The Secretary shall be responsible for insuring that minutes of each Council meeting are prepared and provided to the Council and for maintaining such other Council records as the Council or the co-chairs may direct.

### Section 6. Removal

An officer may be removed by the Council whenever in its judgment the best interests of the Council would be served thereby, but such removal shall be without prejudice to such officer's position as a member. Removal may occur only at a properly called meeting of the Council, after at least thirty days notice to the person proposed to be removed. Any officer may resign at any time by giving written notice to the Council.

Section 7. Vacancy

A vacancy shall exist whenever an officer is removed, resigns, dies, or ceases to be a member of the Council.

Section 8. Agenda

After consultation with the Associate Director of the Division of Mental Health and the members of the Executive Committee, to the extent feasible, the co-chairs shall set the agenda for meetings of the Council and recommend action to the Council and shall insure that a copy of the agenda is mailed to the members of the Council at least seven days prior to any meeting of the Council.

## **ARTICLE VI - COMMITTEES**

Section 1. Appointments

Except for the Council Development Committee and the Executive Committee, the co-chairs, in consultation with the Council, shall appoint all chairs and members of all committees of the Council. The co-chairs may include an additional consumer to maintain a balance of representation on the executive committee. Every member of the Council shall serve on at least one committee, except as may be determined by the co-chairs. Persons who are not members of the Council, including employees of the Division of Mental Health, may serve as members of any standing committee except for the Council Development and Executive Committees. The co-chairs may appoint one or more adolescent consumers to committees of the Council other than the Council Development and Executive Committee. The majority of the members of each committee shall be members of the Council.

Section 2. Executive Committee

There shall be an Executive Committee comprised of the co-chairs of the Council, the treasurer, the secretary and the chair of each standing committee. The Executive Committee may make any decision concerning the affairs of the Council in the interim between properly called meetings of the Council. However, any such action shall be reported to the Council at the next meeting thereof. The Executive Committee shall develop an annual budget for the Council and shall monitor the expenditure of Council funds.

### Section 3. Standing Committees

The standing committees shall be as follows:

- (a) Council Development: This committee shall be comprised of 5 members. One member of the Committee shall be the member of the Council representing the Division of Mental Health. The other members of this committee shall be elected by a vote of the Council at a meeting of the Council to be held prior to June 1st of each year. At least one of the members of the committee elected by the Council shall be a primary consumer. The Executive Committee shall determine the procedures for the conduct of this election and provide written notice of those procedures and of the election itself to the members of the Council at least 30 days prior to the election. This committee shall be responsible for receiving and reviewing applications and nominating members to be members and officers of the Council. This committee shall be responsible: (i) for nominating persons to serve on the council; (ii) for selecting persons to serve as officers of the Council; (iii) for drafting such amendments to the Bylaws as may be needed; (iv) recommending to the Council the removal of any officer or member who is not longer qualified to serve, and, (v) for orienting new Council members. This committee shall also work with the Division of Mental Health to identify state funds to support the work of the Council, may identify and seek other sources of funds, public or private, to support the work of the Council.
- (b) Planning. This committee shall review plans provided to the Council by the State pursuant to 42 USC §300x-4(a) and make recommendations to the Council and the Division of Mental Health for modifications to the plans.
- (c) Substantive Committees. The council shall establish committees relating to the specific areas of services for persons with mental illnesses. There committees shall be responsible for devising a monitoring plan for their area of oversight; interacting with and advising the relevant state, county and municipal entities which provide services within their area of oversight; and, recommending to the Council advocacy priorities within their area of oversight. The substantive committees shall include:
- (i) Adult inpatient mental health services
  - (ii) Adult community mental health services
  - (iii) Children and adolescent mental health services
  - (iv) Persons with mental illnesses in the criminal justice system
  - (v) Any other substantive committees as determined by the Council to be necessary or expedient to carry on the mission of the Council.

### Section 4. Powers

The Committees shall have the power and authority to make decisions only as may be specifically assigned by a majority of a quorum of the Council at a properly called

meeting of the Council. Chairs shall be responsible for keeping minutes of committee meetings and for reporting activities to the Council.

Section 5. Other Committees

Other committees may be appointed by the co-chairs as the Council deems necessary or expedient to carry on the business of the Council.

Section 6. Removal

The chair or any member of any committee may be removed for willful misconduct by a majority of a quorum of the Council at any time at a properly called meeting of the Council.

## **ARTICLE VII--ANTI-DISCRIMINATION**

The Council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child or physical or mental disability.

## **ARTICLE VIII--AMENDMENT OF BYLAWS**

Any member of the Council may propose amendments to these bylaws. These bylaws may be amended by the Council at any time, provided that written notice of such proposed amendment is provided to the Council at least 30 days prior to the meeting at which such amendment is approved and that any amendment is approved by a majority of a quorum of the Council present at such meeting.

### **3. The Role Of The Illinois Mental Health Planning And Advisory Council (IMHPAC) In Improving Mental Health Services Within The State**

#### **Charge, Role and Activities**

The Illinois Mental Health Planning and Advisory Council (IMHPAC) advise the DMH on mental health issues. The Advisory Council is a body of 53 members, which includes consumers and representatives from public and private organizations that plan, operate, and advocate for mental health and support services for persons with serious mental illness. Established in 1992, the Advisory Council's participation in the analysis of Illinois' mental health system has yielded a significant public/private partnership that focused on restructuring public mental health services in Illinois and guided the development of a strategic plan for consumer-responsive, community-based, and cost-effective service delivery. At the end of FY2002, the Council completed work on drafting a set of By Laws, which were approved. These by-laws were revised in FY 2005.

Each DMH Community Comprehensive Service Region (CCSR) is represented on the Council. Providers, consumers, family members and parents of children with SED who are members of the Council may also act in an advisory capacity in the Regions. State employees representing principal state agencies with respect to mental health, education, criminal justice, vocational rehabilitation, housing, and a variety of social services as well as representatives of organizations that are significant stakeholders and advocates are full members of the Council.

The Advisory Council currently has several sub-committees including an Executive Committee, Planning Advisory Committee, and Substantive Committees. The Substantive Committees include: Adult Inpatient, Child and Adolescent Services, Adult Community Services, Mental Health and Criminal Justice. Other committees may be appointed as needed. The Council as a whole meets six times a year to review new developments, monitor the progress of initiatives, and discuss problematic issues in the mental health service system. Each subcommittee also meets six times a year, during alternating months of the full council meeting. Each subcommittee is co-chaired by a consumer or family member and a provider or other council member. The Council advises DMH on its policies and plans, directs committees to communicate with Legislators, DHS administration, and the Office of the Governor in relation to problematic issues, and advocates for improvements in the mental health system. The Council has identified critical funding needs in the public mental health service system, and members of the Council, privately and through their affiliations developed a Mental Health Summit to lobby for additional funding. The focus, coordination, and organization of their efforts have been instrumental in bringing mental health issues to public and legislative attention, founding an infrastructure for further advocacy, and participating in DMH efforts to generate more revenue for community mental health services.

#### **Evidence of Advisory Council Activities**

- As an advocate for adults with SMI and children with SED, and

- Monitoring, reviewing and evaluating the allocation and adequacy of mental health services within the state.

A major focus this year has been the need to generate more revenue for community services and the related project to increase billing Medicaid for services provided by community mental health centers. Members of the MHPAC, including the co-chair, have been closely involved with DMH and other stakeholder groups in developing this process. The President's New Freedom Commission Report and the Surgeon General's Report on Mental Health have been recognized as foundational documents in this ongoing effort.

The activities of monitoring, reviewing and evaluating the allocation and adequacy of mental health services within the state are an integral component of developing the state plan. The Planning Committee of the Advisory Council met with DMH staff to develop and review the state plan, as indicated by the letter from the Chairpersons, Dan Martinez and Tom Troe, which have been included in this application. A copy of the letter from the MHPAC co-chairs endorsing the FY 2007 Illinois Mental Health Block Grant Application is also included.

### **Transformational Activities of the Illinois Mental Health Planning and Advisory Council**

During FY 2008, the IMHPAC Planning Committee has identified two specific goals on which it will focus. The first goal is to hold a retreat for members of the MHPAC in September 2007. The purpose of the retreat is: (1) to engage in a planning process to identify priorities on which the Council will focus over the next two to three years; (2) to develop strategies and action steps to address the priorities, and (3) to clarify the organizational structure and communication structure for the MHPAC as a means of improving on-going planning efforts.

A second goal is to conduct a thoughtful and careful review with regard to how Mental Health Block Grant dollars are currently spent and the impact of the services which are purchased with block grant dollars. The Council will work with DMH staff to find funds that can be used to support the priorities that are identified through the Council's planning process. This process will position the Council to be more effective in advocating for improvements to the public mental health service system.

During the past year, members of the IMHPAC have participated in statewide planning meetings convened by the Division of Mental Health. Based on feedback provided by a wide range of stakeholders, key priorities for the mental health service delivery system have been identified. These priorities include expanding work in the areas of: recovery, implementation of evidence-based practices, supportive permanent housing, children's mental health issues and mental health and justice system involvement.

#### **4. State Mental Health Planning Council Comments and Recommendations**

The comments and recommendations of the IMHPAC are reflected in the letters of support that have been submitted.

# Illinois

## Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

## **Overview of the State's Mental Health System**

### **The Mental Health System at the State Level**

The Illinois Department of Human Services Division of Mental Health (DMH) has a statutory mandate to plan, fund, and monitor community-based mental health services. Through collaborative and interdependent relationships with service system partners, the DMH is responsible for maintaining and improving an evidence-based, community-focused, and outcome-validated mental health service system that builds resilience and facilitates the recovery of individuals with mental illnesses. The DMH accomplishes this responsibility through the coordination of a comprehensive array of public/private mental health services for adults with serious mental illnesses and children/adolescents with serious emotional disturbances.

It is the vision of the Division of Mental Health that all persons with mental illnesses can recover and participate fully in life in the community. Within available fiscal resources, the priority for DMH is to provide access to clinically appropriate, effective and efficient mental health care and treatment for individuals who have serious mental illnesses and who have limited social and economic resources. Planning and budgeting decisions are guided by the basic principle that individuals will receive services in the least restrictive, most clinically appropriate environment, with the best quality of recovery-oriented and evidence-based treatment and care possible.

Statewide efforts to maintain and improve the system of care are coordinated through the Division of Mental Health Central Office based in both Springfield and Chicago. Planning and program implementation are accomplished in conjunction with regional administrators. The Central Office is responsible for oversight of the system, policy formulation and review, the operation of nine state hospitals, planning, services evaluation, and allocation of funds. Interagency collaborative efforts and leadership in initiatives such as activities related to transformation, consumer participation and involvement, the promotion of evidence-based practices, planning for clinical services, forensic services, and child and adolescent services are carried out by statewide administrative staff. There are more than 70 FTE positions in Central Office available to accomplish the manifold tasks required of it. Recently, the Division of Mental Health has been successful at recruiting administrative staff to oversee the increasing responsibilities required of the Central Office. During FY2008, an Associate Director for Transformation, a Quality Manager, a new Chief Fiscal Officer, a new Director for Child & Adolescent Services, a Deputy Clinical Director for State Hospital Operations, Nurse Managers to assist in Quality Management in state Hospitals, and a Decision Support specialist have been hired.

### **DMH Organization at the Local Level: The Community-Based Mental Health Service System.**

Community services are considered the cornerstone of the mental health delivery system. Services provided and purchased by the DMH are geographically based. The DMH is organized into five Comprehensive Community Service Regions (CCSRs). Through these Regions, the DMH operates nine state hospitals and contracts with 151 community

mental health providers across the state. The DMH continually seeks input from consumers, family members, advocates, and representatives of public and private organizations through the framework of the Illinois Mental Health Planning and Advisory Council (IMHPAC) to aid in planning efforts.

Comprehensive Community Service Regions are charged with the responsibility for managing care, developing the capacity and expertise of providers, monitoring service provision and increasing the quality and the quantity of participation from persons who receive mental health services. Two Regions are located in the Chicago Metropolitan area and surrounding suburbs, and three Regions cover the central, southern and metro-east southern (East St. Louis region) areas of the State. Administratively, each Region has an Executive Director, a lead Clinical Director, a lead Recovery Services Development Specialist, and a Coordinator of Forensic Services. Child and Adolescent Service expertise is provided to Regional staff by statewide C&A Services staff who are centrally located.

The DMH uses emerging developments at the local, state and national levels as a basis for strategically setting statewide parameters and goals, with the CCSR carrying the responsibility for the development of congruent local systems of care. CCSR Strategic Plans reflect the overall goal of the development of a recovery-oriented service system which is informed and driven by the vision of the President's New Freedom Commission. Ongoing strategic thinking and planning efforts with Regional stakeholders are designed to uniquely meet local area needs within each Region. The DMH is able to improve linkage and insure that treatment occurs in the least restrictive and most cost-effective settings by integrating hospital-based services into a network of community outpatient services and supports that are coordinated across service providers and consumers. By building on the strengths of communities in which consumers live, the CCSR are able to manage DMH funds, and coordinate the most effective use of the local tax dollars and private resources budgeted for public mental health services.

## **Illinois**

### **Adult - Summary of Areas Previously Identified by State as Needing Attention**

Adult - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

No longer required by SAMHSA CMHS.

# **Illinois**

## **Adult - New Developments and Issues**

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

## **New Developments and Issues Affecting Mental Health Service Delivery**

### **Mental Health Transformation**

DMH and other state entities continue to work toward envisioning and organizing the Illinois transformation effort to meet New Freedom Commission goals. The DMH has convened meetings in which all agencies purchasing or providing mental health services have participated. The meetings were well attended by a wide range of stakeholders, including consumers, family members, advocacy organizations such as NAMI, the Mental Health Association in Illinois, the Illinois Federation of Families, members of the Illinois Children's Mental Health Partnership, and others. Several workgroups were convened in FY2008 to address key components in transformation that were identified in the meetings. In July, 2008 a leadership staff retreat on Strategic Transformation was attended by the Director of DMH, the Chief of Staff and more than thirty clinical, community, and hospital administrative staff from Chicago and Springfield offices and each DHS region. The purpose of the retreat was to further advance the transformation of DMH's services to adhere and align with the vision of ***Recovery as the Expectation*** for consumers of mental health services in Illinois.

### **Community Support Teams**

Community Support Teams have been established by DMH in FY2008 as a core service to support recovery/resilience. The Community Support Model is based on a set of recovery supportive activities and interventions that may be delivered in a highly flexible range of intensity of service, frequency, and modalities including individual, group, and team. Illinois defines community support as consisting of the mental health rehabilitation interventions and supports necessary to assist the individual in achieving rehabilitative, resiliency, and recovery goals....designed to meet the educational, vocational, residential, mental health, co-occurring disorders....financial, social, and other treatment support needs of the individual. Interventions and activities are delivered in natural settings and are targeted toward the management and reductions of symptoms as well as the promotion of stability and independence. Community Support is seen as an active intervention which builds capacity by assisting the individual to do for self and reimbursement is based on medical necessity which includes documentation of psychiatric disability (diagnosis), currently assessed need, an existing service plan with allowed interventions, and a continuing assessment of progress toward achieving recovery/resilience goals. Community Support Team services consist of therapeutic interventions delivered by a team that facilitates illness self-management, skill building, identification and use of natural supports, and use of community resources aimed at decreasing hospitalization and crisis episodes and increasing community functioning in order for the client to achieve rehabilitative, resiliency and recovery goals. For further information, see Adult Plan, Section II, Criterion 1.

### **Permanent Supportive Housing**

Permanent Supportive Housing (PSH) refers to integrated permanent housing (typically rental apartments) linked with flexible community-based mental health services that are available to tenants/consumers when they need them, but are not mandated as a condition of occupancy. The PSH model is based on a philosophy that supports consumer choice

and empowerment, rights and responsibilities of tenancy, and appropriate, flexible, accessible, and available support services that meet each consumer's changing needs. A growing body of knowledge has documented the effectiveness of PSH and helped generate the systems changes needed to create it. The Division of Mental Health is committed to develop an array of Permanent Supportive Housing consistent with the flexible needs of consumers and associated with other new initiatives, i.e., Money Follows the Person (MFP) demonstration project and supportive employment.

Pursuit to create PSH will include new construction or acquisition/rehabilitation of units through new partnerships with housing developers, IHDA, and other housing stakeholders, as well as assisting consumers to lease scattered site rental housing, including studio/efficiency units, one bedroom units, and two bedroom, two-person shared apartments. By increasing the supply of decent, safe, and affordable PSH units, DMH will significantly improve its capacity to help consumers obtain permanent housing that meets their preferences and needs. Consumer choice is important because (1) certain housing features/amenities may support a consumer's recovery goals; and (2) choice in housing correlates with housing and community tenure.

Beginning in FY2008 and forward, DMH is devoting its attention and resources toward expansion of the PSH model while continuing basic support for Supported and Supervised Residential Programs as a fundamental asset in the spectrum of core services. DMH recognizes that a concerted redirection of energy and resources is necessary to ensure that consumers have choice on housing alternatives and that this choice has a foundation based on principles of recovery thereby expanding options for consumers to live independently. Extensive training has been provided to selected DMH staff members who will serve as Regional Housing Support Facilitators (one for each Region). These Facilitators have the task of working with landlord, developers, and local Housing Authorities to promote and create opportunities to develop housing options.

The mental health service definitions already in effect in Illinois provide the direct service modalities that work in tandem with PSH strategies. In most cases and for most individuals the support services necessary to assure successful tenancy are already reimbursable by Medicaid under the Community Support service definition or under other Medicaid plan services (e.g., medication management, psychiatry, outpatient counseling). Provider agencies also have some state Fee-For-Service funding and capacity grant funding to fill gaps for: (a) services for people for whom Medicaid eligibility has not yet been established; and (b) services that are not currently reimbursable under Medicaid.

Bridge Subsidy dollars are the cornerstone to the success of PSH. Bridge dollars have been identified to subsidize rental costs for a targeted population of consumers approved for PSH. Consumers will be required to commit up to 30% of their income for rent, in accordance with HUD standards. The Bridge Subsidy dollars will pay the remaining 70% rental cost. Bridge Subsidy dollars are transitional funding until the consumer receives a permanent voucher either through Section 8 or other housing choice voucher programs. Through the PSH Bridge Subsidy Program, Transition Assistance Funds are also

available to assist consumers' transition to community housing alternatives by providing a set amount of money to pay for items such as application fees, security deposits, utility deposits, and household needs like furniture, small appliances and home making supplies.

The DMH retains national experts from the Technical Assistance Collaborative, Inc. (TAC), to assist in the continued development of creative strategies in planning for Permanent Supportive Housing. In FY2007, the DMH had the opportunity to establish a contractual relationship with the Corporation for Supportive Housing (CSH), a nationally recognized organization in developing and funding PSH housing models. CSH, with an office base in Chicago, has worked with DMH in forging dialogue and partnerships with Illinois Housing Development Authority (IHDA), local housing authorities, housing developers and other finance entities. Several meetings have been and continue to be convened with a broad network of stakeholders to discuss the development of PSH housing arrangements with support service resources. In FY2008, \$7 million was identified from a Hospital Tax Initiative to provide PSH to an estimated 600 consumers of mental health services over a three-year period. An additional amount has been earmarked for the development of a web-based housing stock database to identify available housing stock.

### **System Restructuring Initiative (SRI)**

As noted above, Illinois is continuing work to transition to a fee-for-service system (see Section III-A, Criterion 5). Stakeholders at every level have been involved in the System Restructuring Initiative task force including DMH staff, members of the IMHPAC, consumers of mental health services and their families, and service providers. The SRI has focused on integrating the goal of increasing fee for service revenue with the goal of transition to a recovery-resilience oriented system.

### **The Illinois Mental Health Collaborative for Access and Choice**

Following on the heels of the multi-year System Restructuring Initiative (SRI), a procurement process for an Administrative Services Organization (ASO) led to the selection, in Fall, 2007, of a national behavioral health company to assist DHS/DMH in implementing a number of contractual objectives. The ASO, called the Illinois Mental Health Collaborative for Access and Choice (MHCAC), began operations in December 2007. The Collaborative established their offices in Chicago and in Springfield and named their Illinois CEO in March 2008. The role and function of the MHCAC in the management of the public mental health system in Illinois is far-reaching and encompasses a broad spectrum of administrative activity.

Most prominent among the goals for the MHCAC are to assist the DMH in continued efforts to transition the mental health system to a consumer/ family-centered recovery and resilience-oriented service system, and to assist in the transition from a pre-payment (grant-in-aid) financing system to a post-payment/fee-for-service (FFS) system. Other key objectives include: a) advancement of evidence-based practices, b) prior authorization for priority services, c) precise accountability mechanisms for providers, d) provider network development to insure provider viability and consumer access, e) efficient and effective claims processing/payment mechanisms and post-payment review

that insures that the State is receiving what it is paying for, f) and a state-of-the-art information technology (IT) system capable of supporting implementation of these goals and objectives. MHCAC-DMH work groups have been accordingly established in the following domains: Provider relations, information technology (IT), clinical, ICG, quality assurance (QA), financial, and an overall Implementation Team. The following are highlights the progress of the MHCAC (aka. “the Collaborative”) in implementing several key functions by the end of FY2008:

**Role with Consumers And Families:** Improvements in consumer and family “Access and Choice” referenced in the Collaborative’s title, are predicated on accurate and clear information regarding services, enrollment, etc. and timely communication on a variety of matters, especially changes that would affect consumers as well as responses to consumer questions. Outcomes so far have been:

- A consumer/family handbook. A Spanish version of the handbook is available at the Collaborative website ([www.IllinoisMentalHealthCollaborative.com](http://www.IllinoisMentalHealthCollaborative.com)) and is being printed for distribution in the community.
- A toll free consumer and family care line became operational in January, 2008.
- A DMH newsletter was developed that includes a regular column of Collaborative news and updates.

**Clinical: Prior Authorization And Other Functions** A key goal of the Collaborative contract is to ensure that expensive and intensive services go to those most in need, in the appropriate amounts and duration. In the initial period of implementation the services contingent upon prior authorization are Assertive Community Treatment (ACT), Community Support/Team, and Child /Adolescent Individual Care Grants (ICG). DMH and the Collaborative held a number of technical assistance teleconferences with providers to ensure they are familiar with the authorization process and criteria. The Collaborative began authorizing ACT and CST services at the end of January 2008. Procedures for ICG eligibility/enrollment determination were developed, DMH and the Collaborative held teleconference discussions with ICG providers, and implementation began in April 2008.

**Quality Assurance:** The Collaborative has worked with DMH to develop a QA Plan (to be revised and updated annually as needed). With technical assistance from the Collaborative, DMH established an internal DMH Quality Management Committee that will periodically bring information as well as questions for input to the Mental Health Planning and Advisory Council (MHPAC). The DMH QM Committee is currently creating a study to monitor consumer access.

**Provider Relations, Network Development And Monitoring:** As the purchaser and payer, DMH is responsible for maximizing the overall capacity of this service system, targeting the services to the priority enrollment population, and ensuring accountability to service specification, federal and state statutes and regulations. The Collaborative has been contracted to assist DHS/DMH with these goals and related objectives through implementing efficient and effective mechanisms of claims processing and payment,

post-payment review, provider training and TA, and provider network information management. To date the MHCAC has undertaken a Provider Data Verification project to produce a comprehensive Provider Directory. A Provider Manual has been produced and is available through the DMH and MHCAC web-sites. An interactive, paperless system has been developed by MHCAC for handling all provider-related claims and information exchange.

**Information Technology (IT):** All of the previously enumerated aspects of system restructuring critically depend upon the availability of a state-of-the-art IT system. Such a system must provide DHS/DMH with the capacity for information exchange, storage, and retrieval related to all service and business transactions as well as information necessary for decision-making which optimizes the effectiveness and efficiency of scarce resources. In this area, MHCAC and DMH are working on:

- A Data Warehouse for past and future service and financial data.
- Data Structure for the new IT system:
- DMH and the Collaborative convened a focus group of providers' IT staff in February, 2008 to solicit input regarding technical assistance and training needs.
- The structure, content and timing of regulation reports to DHS/DMH and the provider system.

### **Public Awareness (Anti-Stigma) Campaign<sup>1</sup>**

In FY2008, DMH continued its anti-stigma campaign. Initially, \$200,000 was allocated for an adult public awareness anti-stigma campaign. A children's' mental health public awareness campaign, a collaboration between the Illinois Children's' Mental Health Partnership and the DMH Child and Adolescent Program, is also continuing at an annual cost of \$300,000. In May, 2008, DMH launched the **Say It Out Loud** campaign which will continue through FY2009 and beyond.

In Illinois **Say It Out Loud** is a groundbreaking new statewide campaign to promote good mental health. It is co-sponsored by IDHS/DMH and the Illinois Children's Mental Health Partnership. Research tells us that the best way to reduce the biases associated with mental illness is by sharing experiences. This can be accomplished specifically through interaction with family, employers, colleagues, neighbors and friends, as well as medical and mental health professionals. Based on current research, the campaign seeks to address the misperceptions associated with mental illnesses by giving people the opportunity to engage with one another on the subject in a meaningful way and to share their experiences and knowledge. Thus, the campaign is using the stories of real people in advertisements being distributed to newspapers and radio stations in every county of the

---

<sup>1</sup> Currently there is great dialogue about NOT using the word stigma since mentioning it in of itself reinforces the negative aspect . The same 'anti-stigma' campaign described previously is continuing, but in keeping with SAMHSA's changing the name of their ADS center to eliminate discrimination and stigma from that title and use positive strength based concepts of Acceptance Dignity and Social Inclusion, DMH is accenting a 'public awareness' campaign and eliminating the use of the word 'stigma'.

state, and through videos featured on the campaign's new Web site:  
[www.mentalhealthillinois.org](http://www.mentalhealthillinois.org).

The expectation is that this effort will go a long way towards presenting accurate and positive representations about mental illness and diminishing the barriers that prevent people from seeking or offering help and support. The campaign emphasizes a strength-based approach that presents mental health as a critical component of overall health and well being. It creates both "virtual" and real contact opportunities—with people who have mental illnesses, as well as medical and mental health professionals, family, employers, colleagues, neighbors or friends. It transmits reliable and valued information through the media, the Internet, advertising, word-of-mouth, and through the "stories" that are the essence of the campaign. Visually, the campaign is represented by photographs of people wearing t-shirts emblazoned with their stories of mental health promotion or recovery. The campaign will address the importance of promoting healthy social and emotional development in children and provide early intervention to keep developmental delays or mental health stresses from becoming serious problems. Additionally, DMH is using the campaign to build a larger and stronger base of community support in order to ensure an effective network of programs and services to meet the needs of people living with mental health challenges.

### **Initiatives of the Illinois Department of Healthcare and Family Services (DHFS)**

DHFS, the Illinois Medicaid Agency, is implementing initiatives that impact mental health service delivery. One initiative is the All Kids insurance program that significantly expands medical and mental health services to children across the state. A second initiative is Disease Management, which seeks to manage and coordinate services across service systems for individuals with targeted diagnoses.

# Illinois

## Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

### **Legislative Initiatives And Changes**

During FY 2008, several key legislative initiatives were passed that will have some impact on the landscape of mental health service delivery in Illinois.

The Governor signed legislation in July 2007 that allows Illinoisans living in rural communities increased access to psychiatric care. Public Act 95-16 permits rural Medicaid patients to receive treatment through telepsychiatry-primarily videoconferencing - to provide psychiatric care despite the distance. This addresses the shortage of psychiatrists working in rural communities, a problem that affects not only Illinois, but the nation. Many persons with mental illness live a long distance from a mental health facility and have limited access to transportation, making it difficult to obtain adequate mental healthcare. The new law requires the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally qualified health centers (FQHCs) for mental health services provided via tele-psychiatry. Illinois joined more than ten other states that have similar regulations in place. Upon signing the bill, the Governor said. "Everyone who needs psychiatric care should be able to get it, regardless of where they live. The use of tele-psychiatry is an exciting step in expanding access to healthcare for all."

A new law clarifying the definition of "children with disabilities" establishes uniformity in the School Code making students statewide eligible to receive special education services up until the day of their 22nd birthday. It helps assure that students with disabilities are able to continue to receive the educational services they need to become productive adults. It provides Illinois schools with clear guidance on their responsibilities in this area and provides these students with a stronger foundation for life after graduation.

### **Moving from Institution to Community: Olmstead Activities**

Since the Supreme Court ruling in the case of Olmstead vs. L.C. issued in June, 1999, which stated that the unjustified institutionalization of people with disabilities is a form of discrimination under the Americans with Disabilities Act (ADA), Illinois, as other states, has been working on a state Olmstead Plan. DHS was assigned the lead role in developing the State's Olmstead Plan and organized the Disabilities Services Advisory Committee (DSAC) which is comprised of a wide-range of stakeholders and has been established by statute. In FY 2006, DSAC developed a strategic plan, which was submitted to and approved by the Governor and the Legislature. The Plan and updates are available on the DHS Website at <http://www.dhs.state.il.us/projectsInitiatives/dsac/>.

### **DMH and Disaster Response Activities**

The Robert T. Stafford Act of 1974 (Public Law 93-288) created the system in place today by which a Presidential Declaration of an emergency triggers financial and physical assistance through the Federal Emergency Management Agency (FEMA) thereby initiating an orderly and systemic means of federal natural disaster assistance for state and local governments in carrying out their responsibilities to aid citizens. The Governor

has designated the DMH as the State agency to lead disaster resource coordination and recovery functions related to mental health. Working in the context of the overall State-wide Disaster Plan and the Illinois Emergency Management Administration (IEMA) as well as the State Emergency Operations Center (SEOC), DMH coordinates Illinois' disaster preparedness for state operated and state funded psychiatric service providers. Through the Comprehensive Community Service Regions, DMH assists in the development of local response capability for issues of Mental Health. The operational focus includes collaboration with other state agencies, monitoring, and facilitating ongoing concordance with National Incident Command Systems (NIMS). DMH participates in Substance Abuse and Mental Health Services (SAMHSA) Grant applications and collaborates with qualified partners in providing training. DMH also develops plans and mechanisms to coordinate surge deployment of mental health services in response to disasters, be they natural or caused by terrorists.

A Statewide Mental Health Disaster Preparedness Plan has been developed which recognizes the concept of local response to disaster mental health needs of Illinois communities and which builds on the strengths of the communities. Each Region has a designated Disaster Resource Coordinator to identify lead providers for each Region (generally by county for most of the state).

In recognition of the potential for natural or terrorist caused disasters in the State, emphasis in disaster planning has been on developing and/or maintaining a local response capacity. This includes educational offerings and the availability of trained mental health professional and paraprofessional volunteers to respond to the needs of their community in time of crisis. A central list of Illinois mental health professionals who were willing to be deployed on an urgent (surge) basis is continually updated as a resource in the event of future terrorist aggression or disaster requiring a mental health response. As necessary, the Red Cross may draw down the volunteers in groups. DMH continues to provide training on disaster response in conjunction with other state agencies and entities.

During FY 2006, like many states, Illinois offered assistance to Hurricane Katrina evacuees. As the state lead on mental health in disaster planning, DMH applied for, and received an Immediate Services Program (ISP) Crisis Counseling Grant to provide services to evacuees. DMH further applied for a Regular Services Program (RSP) grant to continue the program beyond the initial period and was one of seven states awarded an RSP. Illinois was awarded an Immediate Services Program for \$368,000 and Regular Services Program for \$643,104 jointly by SAMHSA and FEMA to provide crisis counseling to individuals displaced to Illinois by Hurricane Katrina. In March 2008, floods devastated the counties of Iroquois and Livingston. A federal declaration was made prompting DMH to apply for and receive a SAMHSA grant. This grant was an Intermediate Services Program award for \$33,802. Additionally, in June 2008, the President declared 18 Illinois counties as disasters due to significant floods. However, Individual Assistance was unwarranted due the local areas' abilities to manage the influx of mental health needs in their respective communities. Preliminary Damage Assessment reports also demonstrated a greater need for Public Assistance (the second of two versions of related assistance offered by SAMHSA).

## **Veterans' Services**

The Illinois Warrior Assistance Program provides confidential assistance to Illinois Veterans as they transition back to their everyday lives after serving our country. The goal of the program is to help service members and their families deal with the emotional and psychological challenges they may be facing. A 24-hour, toll free helpline is staffed by health professionals to assist veterans day or night, with any of the symptoms associated with Post Traumatic Stress Disorder (PTSD). Traumatic Brain Injury (TBI) screenings are provided to all interested veterans. TBI screenings are mandatory for all returning members of the Illinois Army National Guard and Air National Guard.

# Illinois

## Adult - Description of Regional Resources

Adult - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

No longer required per SAMHSA CMHS.

# Illinois

## Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

### **Leadership & Coordination Of Mental Health Services-The Broader System:**

DMH exerts ongoing leadership through system integration initiatives, competence development, consumer development and continuous quality improvement. Emphasis is on developing systems integration at the statewide level that parallels the relationships that community mental health centers develop at the local level. The DMH provides leadership by coordinating mental health services with the broader system through the integration of services with other IDHS divisions and working closely with the code departments and organizations at the state level.

### ***Relationship of the DMH to the Illinois Department of Human Services (IDHS).***

The Illinois Department of Human Services (IDHS) is the cabinet level state agency which manages human service systems in the State, including management of the public mental health system through the Division of Mental Health. The mission of the IDHS is to assist Illinois residents in achieving self-sufficiency, independence and health to the maximum extent possible by providing integrated family-oriented services, promoting prevention, and establishing measurable outcomes in partnership with communities. The IDHS is able to connect eligible clients to a wide range of human services at one location because it administers community health and prevention programs, oversees programs for persons with developmental disabilities, mental health and substance abuse problems, provides rehabilitation services, and helps low-income persons with financial support, employment, training, child care, and other necessary family services. Local office staff use a family-centered approach to identify client needs; determine eligibility for benefits; link clients to appropriate programs, and refer them to services in their community. Increasing systems integration among the divisions and offices of IDHS improves the accessibility of support services for the mental health service system and enhances service delivery for individuals coping with mental illness.

### **IDHS Service Areas**

**Division of Human Capital Development (DHCD).** The DHCD oversees programs that help clients to achieve self-sufficiency including employment and training services, child care and family services, and financial support services. This Division serves over one million DHS customers each month through income supports such as: cash assistance, food stamps, medical programs, employment and training programs, help with child care, emergency assistance, refugee and immigration services, homeless services, and specialized social services. DHCD has six regional and 115 local Family Community Resource Centers that serve as the first point of contact for many IDHS clients. These offices offer direct transitional services and a link to employers and key community organizations.

### ***DMH and the State Welfare Program***

In an ongoing effort to address issues that may provide barriers to work readiness, the DMH and the DHCD work together in establishing and managing liaison relationships between local community mental health centers and local IDHS offices. The aim is to identify customers of IDHS who may be in need of mental health services (screening, assessment, and treatment). Through provider agencies, DMH funds eleven full or half time Qualified Mental Health Professional (QMHP) staff positions onsite at eleven designated IDHS Family Community Resource Centers. Of these, six DHCD offices

located in the Metro Chicago area have a full-time QMHP, one has a part-time QMHP, and four offices in Greater Illinois have the presence of a part-time QMHP. Paralleling this co-location is a statewide collaborative effort involving 97 DMH-funded mental health centers that have liaison relationships with the remaining local DHCD offices. These liaisons have a presence in IDHS offices for a minimum of four hours a month. Currently, each DHCD office has a liaison assigned to interface with the mental health center administration.

**Community Health and Prevention.** The Division of Community Health and Prevention (DCHP) encompasses community health services, family and youth development, violence prevention and intervention and addiction prevention. The DCHP includes: Maternal and Child Health Services, Comprehensive Services for Youth, Substance Abuse Prevention, the Teen REACH Program and Violence Prevention and Education Services.

#### *DMH Work with Community Health and Prevention*

Collaboration, cross training, and consultation between DMH and Division of Community Health and Prevention (DCHP) has continued:

- A statewide perinatal mental health consultation service has been established for providers to use when a screening indicates that a pregnant or postpartum woman may be suffering from depression. This service is accessed by a toll free number and provides consultation with psychiatrists, information about medications that may be used in the management of perinatal depression during and/or after pregnancy, and referral and linkage to available mental health resources.
- Early Intervention Services provided through DCHP for children under three years of age who are experiencing delays in one or more of the following areas: cognitive development; physical development; language and speech development; psycho-social development; and self-help skills. Evaluations and assessments are provided at no cost to families. Families with eligible children receive an Individualized Family Service Plan (IFSP) which lists the services and supports which must be made available to the family.

**Alcoholism and Substance Abuse.** The Division of Alcoholism and Substance Abuse (DASA) administers and monitors funding to a network of community-based substance abuse treatment programs. These programs provide a full continuum of treatment including outpatient and residential programs for persons addicted to alcohol and other drugs.

#### *The Challenge of Co-Occurring Disorder (MISA): Joint work by DMH and the Division of Alcoholism And Substance Abuse*

The Report of the Surgeon General on Mental Health, published in 1999, based on an extensive literature review of relevant and timely research, clearly stated that:

“ As many as half of people with serious mental illnesses develop alcohol or other drug abuse problems at some point in their lives....Theories to explain co-morbidity (also known as dual diagnosis) range from genetic to psychosocial, but empirical support for any one theory is inconclusive. In short, the cause of such widespread co-morbidity is unknown. Co-morbidity worsens clinical course and outcomes for individuals with mental disorders. It is associated with symptom exacerbation, treatment noncompliance,

likelihood of suicide, incarceration, family friction, and high service use and costs...". (U.S. Department of Health & Human Services, Mental Health: A Report of the Surgeon General, Rockville, MD, 1999: pp288-289)

DMH and the Division of Alcoholism and Substance Abuse (DASA) have collaborated to address services for individuals with co-occurring disorders for many years. Initiatives have included the establishment of consortiums comprised of mental health and substance abuse providers to collaborate on treatment provision, cross-training of providers from both service systems focusing on integrated treatment, and the funding of an institute to provide training to service providers across the state. Additionally DMH and DASA have participated in the SAMHSA National Policy Academy on co-occurring disorders. Staff members of both Divisions are actively working together to implement integrated treatment. Currently DASA funds more than 20 agencies statewide to provide both mental health and substance abuse services to persons with co-morbidity. The DMH and DASA jointly applied for and received, a SAMHSA grant for training providers and evaluation of the implementation of Integrated Dual Diagnosis Treatment (IDDT).

**Developmental Disabilities Services.** The Division of Developmental Disabilities (DDD) provides respite care, developmental training, and family support services to help individuals with developmental disabilities to become independent. Services are provided through residential facilities and programs that help disabled individuals live at home or in a community living center. Joint efforts are ongoing to resolve service issues for those consumers who have been dually diagnosed with a developmental disability and a mental disorder.

*Addressing Autistic Spectrum Disorders (ASD): Shared Leadership by DMH and the Division of Developmental Disabilities*

Both divisions share leadership tasks in addressing the needs of persons with Autistic Spectrum disorders (ASD). In FY 2004, a multi-agency Autism Task Force was established. The momentum and energy engendered by the Task Force dovetailed into complementary action by the Illinois legislature. Public Act 093-0773, An Act in Relation to Persons with Disabilities, directed the IDHS to convene a special task force to study and assess the service needs of persons with ASD. In FY 2005, the Division of Developmental Disabilities (DDD) and the DMH co-convened the Autism Task Force that continues to meet.

**Rehabilitation Services.** The Division of Rehabilitation Services (DRS) oversees programs serving persons with disabilities that include vocational training, home services, educational services, advocacy, information and referral. Also provided are a variety of services for persons who are blind, visually impaired, deaf or hard of hearing.

*Supportive Employment and Recovery Specialization: The Collaborative Efforts of DRS and DMH*

DMH and DRS actively collaborate to increase the access of persons with serious mental illnesses to vocational rehabilitation services and to improve the coordination of psychiatric and vocational services. Since FY 2004, the DMH and DRS have expanded their efforts in the development and provision of Certified Recovery Support Specialists training for consumers and the development of self-employment opportunities that are integrated with appropriate support services. Sixty (60) recovery support specialists were

trained and certified in FY 2006. DMH, DRS, and DASA worked collaboratively with the Illinois Certification Board (ICB) during FY2007 to develop the Illinois Model for Certified Recovery Support Specialist (CRSS) that defines baseline criteria for CRSS professionals and provides a professional certification that is competency based. DMH and DRS continue to jointly assess their service systems to determine what gaps exist locally and emphasize technical assistance for needed program modifications.

***Relationship of the DMH to the Illinois Departments and Organizations.***

**Illinois Housing Development Authority**

*Activities Related to Housing*

The availability of adequate, safe, affordable housing is a necessary component of a comprehensive community support system. The DMH, through its Comprehensive Community Service Regions, is committed to pro-active involvement in expanding the pool of affordable, supported housing for persons with psychiatric disabilities. DMH has worked at forging dialogue and partnerships with the Illinois Housing Development Authority (IHDA), a group with a legislative mandate to oversee and advise on Housing in Illinois, which includes the broader spectrum of state government in its membership, as well as local housing authorities, housing developers and other finance entities. Many DMH local contracted community mental health vendors have worked with HUD to develop housing opportunities for individuals who are homeless through the Shelter Plus Care Project and 811 Project to pave the way for local housing development. DMH Regions continue to encourage local vendors to explore avenues for capital development for new construction and rehabilitation, as well as the availability of existing resources, such as public housing. DMH staff also work closely with the Department of Human Rights and the Attorney General to support the needs and rights of mental health consumers when there is community resistance to develop housing for persons with a history of mental illness. With the support of these and other partners, DMH is currently implementing a Permanent Supportive Housing (PSH) initiative. PSH can either be tenant based or site based models, with consumers holding leasing rights outlined in a lease agreement. Support services are flexible and by choice, and are not a requirement to maintain occupancy. Safe, decent, and affordable housing opportunities are being emphasized.

**Illinois Department on Aging**

The DMH works closely with the Illinois Department on Aging (DOA) to increase training opportunities in the geriatric field, to improve the quality and accessibility of services for elderly persons with mental illness, and to enhance networking, collaboration and coordination of programs and services in provider networks. The DMH continues to jointly coordinate an Advisory Committee on Geriatric Services with the DOA. The Advisory Committee focuses its efforts on the assessment of the mental health needs of the elderly, as well as identifying model programs, best practices and staff competencies to serve this population. The committee has provided training, consultation and technical assistance in the area of mental health and aging and has promoted public awareness of geriatric mental health concerns. In FY2008, the DMH, in coordination with the DOA, successfully convened its annual Mental Health and Aging Conference. The DMH also continues to fund a Geropsychiatric Specialist Initiative that provides support for the

development of local mental health and aging coalitions, education and training on older adult mental health issues, and consultation to DMH case managers and aging personnel.

## **Illinois Department of Public Health**

### ***Suicide Prevention***

In Illinois, more than 1,000 persons die by suicide each year and suicide fluctuates yearly between being the second or third leading cause of death for adolescents. Interest, organized efforts, and advocacy for suicide prevention in Illinois began in 2001. By 2003, a suicide prevention group had completed a draft plan which included key recommendations for suicide prevention. In 2004, the Suicide Prevention, Education and Treatment Act (PA093-0907) was passed by the General Assembly and signed by the Governor directing the Illinois Department of Public Health (IDPH) to appoint an advisory board entitled the Illinois Suicide Prevention Strategic Planning Committee. The committee represents statewide organizations and other agencies that focus on the prevention of suicide and the improvement of mental health treatment, that provide suicide prevention services and support services to survivors. The committee was charged with the development and implementation of the Illinois Suicide Prevention Strategic Plan. In addition to the plan, the committee was also charged with convening a statewide conference on suicide prevention, conducting media and public awareness campaigns, formulating education initiatives, and contingent upon funding, setting up five pilot programs to provide training and direct service. The Illinois Suicide Prevention Coalition (ISPC) which includes a wide range of people from across the state concerned with preventing suicide and suicide attempts, assists IDPH to mobilize agencies and individuals around the issue of suicide prevention. In 2007 an alliance was formed between the ISPC and the strategic planning committee to unify their strengths and advance the plan. The joint mission of this alliance which was recognized in law by the General Assembly in 2008, is "to reduce suicide and its stigma throughout Illinois by collaboratively working with concerned stakeholders from the public and private sectors to increase awareness and education, provide opportunities to develop individual and organizational capacity in addressing suicide prevention, and advocate for access to treatment." DMH is a member of the Alliance and has actively participated in the development of the 2007 Illinois Suicide Prevention Strategic Plan. The Plan may be found at:

[http://www.idph.state.il.us/about/chronic/Suicide\\_Prevention\\_Plan\\_Jan-08.pdf](http://www.idph.state.il.us/about/chronic/Suicide_Prevention_Plan_Jan-08.pdf)

## **Illinois Department of Public Health and**

## **Illinois Department of Healthcare and Family Services**

### ***Mental Health Issues in Long Term Care***

There are a substantial number of individuals with serious mental illnesses who require long-term care services. Some require this level of care because of functional limitations associated with their mental illness, and others require it for functional limitations associated with both mental illness and medical needs. The Illinois Department of Public Health (DPH) is responsible for monitoring the licensing requirements of nursing facilities, and the Department of Healthcare and Family Services (DHFS) oversees Medicaid funding. The DMH has made a concerted effort to assist community providers and these two state agencies to understand the service needs of persons with serious and disabling mental illnesses and the long term care service options that are available.

### **The “Money Follows The Person” Initiative**

Illinois will receive an estimated \$55.7 million in new federal funding over five years to help people living in nursing facilities return to their homes or a community residence. The “Money Follows the Person”(MFP) grant will facilitate the transition of approximately 3500 persons into their home communities over the course of five years. In addition to the federal award, the state has also committed \$23.8 million to this expansion of home and community-based services. The Department of Healthcare and Family Services, the lead agency for the initiative, is working closely with the IDHS divisions of Developmental Disabilities (DDD), Rehabilitation Services (DORS) and DMH, the Department on Aging, and the Illinois Housing Development Authority on the project. IDHS is committed to maximizing this funding in support of the goals of consumer self-direction, independence and community reintegration. Programs under the MFP grant are designed to: (1) Eliminate barriers or mechanisms that prevent Medicaid-eligible individuals from receiving support for appropriate and necessary long-term services in the setting of their choice; (2) Increase the ability of the state Medicaid program to assure continued provision of home and community-based long term care services to eligible individuals who choose to move from an institutional to a community setting; and (3) Ensure that procedures are in place to provide for continuous quality improvement in these services for individuals receiving Medicaid home and community-based long-term care. Illinois has completed its federally required operational protocol that was accepted in May 2008. DMH is currently participating in the identification of appropriate candidates for transition to the community and is identifying and contracting with provider agencies for the provision of services. As DMH moves forward into shared implementation of the initiative, policies and procedures are being developed to facilitate the provision of mental health clinical and support services.

### ***Mental Health and the Justice System***

In addition to oversight and management of inpatient hospital services for persons with mental illnesses who have been declared unfit to stand trial (UST) or not guilty by reason of insanity (NGRI), the DMH Forensic Services collaborates with a range of agencies in the Criminal Justice System including:

- Illinois Department of Corrections
- Illinois Department of Juvenile Justice (Established in FY2006)
- Administrative Offices of the Illinois Courts
- Illinois Criminal Justice Authority
- Illinois State Police
- Illinois Sheriff's Association
- Cook County Department of Corrections
- County Jails and Juvenile Detention Centers (statewide)
- Local Law Enforcement agencies and organizations (statewide).

The following four initiatives are highlighted as these clearly demonstrate leadership and an increasing clinical role in serving individuals with mental illnesses who have been adjudicated in the criminal courts:

### **The Jail Data Link Project**

A pilot program between the Cook County Department of Corrections (CCDOC) and the mental health system begun in FY2000 has now expanded to other sites around the state. The initial program effort was implemented through Thresholds, a community mental health center, and was designed to serve adults diagnosed with serious mental illnesses who are detained at CCDOC (pre-trial). The project received a Gold Award from the American Psychiatric Association. A key aspect of this project was the development of a database for the daily exchange of information between Cook County Jail and the community mental health provider. The learning experienced from this project, which is referred to as the Jail Data Link Project, was used to expand the project to Will, Peoria and Jefferson counties. This initiative is more fully described in Section III of this application.

### **Rockford Crisis Services Collaborative**

In the Rockford area, a collaboration between DMH Forensic services staff, Janet Wattles Community Mental Health Center, Singer Mental Health Center, and Rockford Jail liaisons developed strategies for providing post release and emergency mental health services to detainees of the Rockford Jail. The emphasis of services is on detainees with misdemeanors who are known to local mental health providers. As a result, a mental health court was established that provides for diversion, discharge planning, and service linkage to Janet Wattles Community Mental Health Center. This program began initial operations during FY 2005.

### **The Mental Health Juvenile Justice Initiative**

The DMH has a Juvenile Forensic Program that develops treatment programs for forensic youth who are court-ordered into mental health care (i.e. unfit to stand trial or not guilty by reason of insanity). The Juvenile Forensic Program oversees the DMH Mental Health Juvenile Justice Initiative (MHJJ), which links minors in juvenile detention centers who have a major mental illness and sometimes co-occurring substance abuse problems to comprehensive community-based care. MHJJ began as a pilot program in FY2000 and expanded statewide by the end of FY2002. Funding is provided to support local agencies in employing a Masters level clinician who serves as a liaison and works with the minor, the minor's family, the court, the detention center, and local community agencies to develop a community wraparound plan that is intensive, integrated and specialized. Participants in the MHJJ program have been found to exhibit significant clinical improvement within three months. These youth have also been found to have better school attendance and a lower re-arrest rate. MHJJ is available at all the detention centers in Illinois.

### **Law Enforcement and Crisis Intervention Training**

The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons who are in crisis. Each DMH Region is committed to working on improving relationships through cross-training events for law enforcement officers and mental health staff of community agencies. DMH has worked collaboratively with a number of law enforcement agencies to provide training targeting police officers that interface with individuals with mental illnesses. Topics have included mental illness crisis and police

response. DMH has also provided partial funding, and worked with the Illinois Law Enforcement Training and Standards Board (LETSB) to develop a one day training program targeted for experienced police officers on working with individuals who have mental illness and are in a behavioral crisis. On-going training in the curriculum has been implemented in 16 Mobile Training Units (MTU) covering the state. The DMH has also worked with the Illinois Sheriff's Association to examine the issue of the persons with mental illness in county jails and to develop model protocols for mental health screening, suicide, and referral to mental health providers.

### **Illinois State Board of Education**

### **Chicago Public Schools**

#### ***DMH and the Education System***

The DMH has pursued the Positive Behavioral Interventions and Supports (PBIS) model of collaboration between education and mental health primarily through work on the System of Care Grant and through collaborative efforts with the Children's Mental Health Partnership. Work is continuing to expand the education/mental health partnership and to utilize existing expertise to produce a replicable model for this collaboration. Discussions have been held with the Office of the Mayor of Chicago, the Chicago Public Schools, and child-serving state agencies to identify the needs of students and their families for a range of mental health services. A work group has been established which includes university researchers, mental health providers, educators and technical advisors who have designed universal, selected and targeted interventions to meet student and school needs.

#### **Illinois Department of Children and Family Services (DCFS)**

DMH continues to work closely with DCFS, the child welfare agency, on a number of initiatives including Screening, Assessment, and Support Services (SASS) and a training initiative for child welfare staff and service providers to examine and respond to the trauma children and families have experienced as a result of physical abuse, neglect, sexual abuse and domestic violence and its effect on their behavior, performance and adjustment, especially in foster care and other supportive environments. For more information, see the Child and Adolescent Plan, Section II, Criterion 3.

# Illinois

## Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

The Overview section reported in the adult section pertains to the organization of the public mental health system for adult and child services. Please see the referenced section.

## Illinois

### Child - Summary of Areas Previously Identified by State as Needing Attention

Child - A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.

No longer required.

# Illinois

## Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

The New Development section reported under Adults pertains to the adult and child issues. Please see the referenced section.

# Illinois

## Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

The Legislative initiative section reported under Adults pertains adult and child issues. Please see the referenced section.

# Illinois

## Child - Description of Regional Resources

Child - A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.

No longer required per guidance from SAMHSA CMHS

# Illinois

## Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

The description of leadership of the state mental health agency in coordinating mental health services in the section reported under Adults pertains to the adult and child issues. Please see the referenced section.

# Illinois

## Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

# **ADULT SERVICES PLAN**

## **SECTION II: IDENTIFICATION AND ANALYSIS OF SERVICE SYSTEM STRENGTHS, NEEDS AND PRIORITIES**

### **Plan Organization**

*As the Illinois Mental Health Authority, the DMH is responsible for public mental health services for both children and adults. The previous organization of the plan reflected this service integration. The organization of the FY 2009 Block Grant Plan continues the transition begun in FY2007. The Illinois DMH Block Grant Plan for FY 2009 is organized separately for adults and children. Section II and Section III are each organized within the context of the five legislative criteria. This organization is reflected in the Narrative Sections II and II-A, as well as in Section III-B which contains the relevant system performance indicators. Section II describes the service system and Section III-A provides the context for the objectives specified for FY2009 that relate to comprehensive mental health service delivery. Transformation activities and progress are discussed in Section III-C.*

### **Criterion I: The Comprehensive Community Based Mental Health System**

#### **Organizational Structure of the Illinois System of Care**

##### **Overview**

Illinois has made substantive progress in developing a comprehensive mental health service system for individuals with serious mental illnesses (SMI) and for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced and transformed mental health system that is consumer directed and community driven providing a continuum of culturally inclusive programs which are integrated and effective, a range of direct and support services (including prevention, early intervention, treatment and supports), that support healthy lifelong development through equal access and promote recovery and resilience. The Illinois Vision for Mental Health is that:

“All persons with mental illnesses can recover and participate fully in community life:

- The expectation is recovery
- The consumer is central

Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality.

##### **Organization of the Comprehensive System.**

DMH services are organized around five geographic Comprehensive Community Service Regions (CCSRs) responsible for contracting activities with 151 community-based outpatient/rehabilitation agencies and 27 local hospitals statewide that provide psychiatric programs. The DMH is also responsible for oversight of public inpatient beds in nine state operated hospitals. The CCSR s are also responsible for integration of a

comprehensive care system which includes mental health, rehabilitation, substance abuse, social services, criminal justice, and education. Each CCSR has assigned staff specially designated to address child and adolescent and Forensic services. Being part of IDHS has provided an opportunity for the DMH to address a number of challenges within the shared mission of one Department, including: disability determination for persons with serious mental illnesses (SMI), integration of vocational and psychiatric rehabilitation services, coordination and development of Mental Illness and Substance Abuse (MISA) services and, through the coordinated intake process, an opportunity to enhance case finding, early identification, and outreach efforts.

### **The Growth of Community-Based Services.**

Within Illinois there are numerous private practitioners, community mental health agencies, community hospitals providing inpatient psychiatric care, and community long-term care facilities providing services to individuals with serious mental illnesses. Over the past 30 years the locus of treatment for persons with mental illness has shifted from institutions to community-based settings. In FY1973, 8% of the DMH's budget was allocated for community services. Today more than 70% of DMH expenditures are allocated for community-based services. In FY2007, the DMH purchased community based services for more than 179,000 individuals and provided state hospital services for over 10,200 individuals.

### **Available Services and Resources in the Comprehensive System of Care**

#### **Health, Mental Health and Rehabilitation Services**

##### ***Health Services***

***"There is no Health without Mental Health"*** has been the slogan of the Division of Mental Health for the past seven years. The diagnosis and treatment of mental disorders is inextricably woven into the broader context of an individual's physical health. Physicians in general practice are very likely to be the access and linkage point for psychiatric services, especially for persons suffering with depressive and anxiety disorders. On the other hand, psychiatrists should be cognizant of the medical issues being faced by the patients they see and be prepared to refer them to other appropriate medical specialties. Individuals with serious mental illnesses who are Medicaid recipients are entitled to the range of health services covered in the Illinois Medicaid plan. DMH continues to emphasize the importance of assisting adult consumers in the completion of an application for Medicaid services as one means of assuring that access to health services are available. The establishment of relationships between Federally Qualified Health Centers (FQHCs) and DMH funded community mental health agencies has also been emphasized. An initiative recently implemented by the Department of Health Care and Family Services (DHFS) follows a Disease Management model. Illinois Health Connect is a statewide Primary Care Case Management (PCCM) Program for most persons covered by DHFS medical programs. People who are enrolled in Illinois Health Connect will have a "medical home" through a Primary Care Provider who will coordinate and manage their care. This program will benefit many consumers of public mental health services both children and adults. Additionally, a second program, Your Healthcare Plus, employs health care teams to assist with problems of chronic diseases

including mental illness and uses an “action planning” approach to help consumers understand their illness, how to cope with it and work constructively with their doctors. In April, 2008, CMS awarded twenty grants to twenty states for two year projects with the goal of reducing the use of hospital emergency rooms by Medicaid beneficiaries for non-emergent reasons. The anticipated outcomes of these grant-funded projects are improved access to, and quality of, primary healthcare services, improved beneficiary health status and demonstrated program cost savings. DHFS, in partnership with DMH, applied for and received a \$2,000,000 Medical Emergency Room Diversion (ERD) Grant.

### **The Array of Core Mental Health Services**

The array of core mental health services purchased on behalf of Illinois citizens with mental illnesses are based on the tenets of the Community Support Program (CSP) and Child and Adolescent Support Services (CASSP) models. They are described in the Provider Handbook which has been issued by the Mental Health Collaborative, the administrative services organization which is assisting DMH with the organization and evaluation of service delivery. The following is a brief summary of the core services.

#### **Acute Care.**

Acute Care Program services provide a rapid response to individuals in a mental health crisis, to members of the individual’s support system and the community on a 24-hour a day basis. Such services are intensive, short-term and are oriented toward stabilization of the individual’s condition and management of disruptive and life threatening symptoms. Services include crisis-emergency services (e.g. mobile, walk-in and telephone response, crisis residential services and hospital-based services).

#### **Mental Health Treatment - Outpatient**

These core services are delivered to consumers who have been determined on the basis of a mental health assessment to have a mental illness or emotional disturbance with significant impairment in role functioning. Outpatient services that are intended to reduce psychiatric symptoms and promote adaptive functioning are based on an evaluation of an individual’s mental health service needs and an individual treatment plan (ITP) that is monitored, reviewed, and modified as needed on an ongoing basis. These services include:

- Assessment, Treatment Planning and Monitoring;
- Counseling and Therapy Services;
- Psychiatric Services:\*
- Medication-related Services; and
- PAS/MH Services (Long Term Care screening and assessment service).

#### **Psychiatric Services\***

Psychiatric Services are a primary core service in mental health treatment programs. It is noteworthy that block grant dollars allocated to Illinois have largely been directed to improving the quality and availability of this vital clinical service through further infrastructure development. Funds are being used in recruitment and retention of

qualified psychiatrists, and to further collaboration with medical schools. This initiative was one of the three top priorities to increase access to quality psychiatric services in areas of critical need cited by the Illinois Mental Health and Planning Advisory Council (IMHPAC) for both adults and children. Substantive progress has been made in actualizing this initiative.

### ***Rehabilitation Core Services***

Rehabilitation core services which are funded include:

- Psychosocial Rehabilitation,
- Assertive Community Treatment (ACT).
- Community Support and Case Management
- Client Transitional Subsidy; -a temporary short-term assistance for medication, clothing and housing support in order to facilitate a consumer's resettlement in the least restrictive, community integrated setting possible.
- Transition to Adult Services.
- Residential Support Services- for promoting community adjustment and long-term recovery and relapse prevention.
- Residential services -including supported residential and supervised residential services.

### ***Additional Support Services Funded and Provided through DMH:***

**Psychiatric Medication** provides resources for psychiatric medications primarily to adults with serious mental illnesses or children/adolescents with serious emotional disturbance who have insufficient insurance coverage or private resources to pay for them. Three (\$3) million in General Revenue Funds (GRF) have been budgeted yearly to increase accessibility to psychiatric medications. The program targets persons discharged from hospitals and waiting for Medicaid reinstatement, SSI/SSDI applicants waiting for initial Medicaid or All Kids eligibility determination, or applicants for pharmaceutical indigent programs awaiting access. The priority is to access the medications, which produce the most favorable clinical outcome as determined by the treating psychiatrist.

**Community Integrated Living Arrangements** provide a funding mechanism for an individually-tailored array of supportive services for individuals residing under the supervision of the service provider which promotes residential stability for an individual who resides in his or her own home or in the natural family home.

**Emergency Psychiatric Services** are provided through a hospital-based service model and include, emergency room psychiatric consultation and assessment activity, crisis/observation beds, transportation, emergency purchase of medications (short term), partial hospitalization, and inpatient hospitalization.

**Community Psychiatric Hospitalization** provides inpatient psychiatric hospitalization in a community hospital for persons experiencing acute psychiatric conditions.

### **Employment Services**

Supported Employment Services are based on the financial and service integration of the DHS Division of Rehabilitation Services (DRS) funded vocational services and resources with DMH funded mental health treatment and supportive services. DMH and DRS have collaborated closely in a joint effort -“The Brand New Day Initiative” - to increase access to vocational rehabilitation services including supportive and subsidized employment for persons with serious mental illnesses and to improve the coordination of psychiatric and vocational services. Locally, services are obtained through joint planning and service efforts by community mental health centers (CMHCs) and local offices of DRS. This collaboration addresses the needs of both adults and youth.

Supported Employment is an evidence-based practice shown to improve employment rates of persons with serious mental illnesses by as much as 60%. DHS currently has two grants to implement this model in Illinois: a NIH grant to address state infrastructure issues and a Johnson & Johnson/Dartmouth Community Mental Health Program Grant which supports implementation at 4 pilot sites.

Eleven mental health agencies, in partnership with their local DRS offices, are piloting the implementation of Evidence-Based Supported Employment (EBSE). From September 1, 2006 to June 30, 2007, 1,096 individuals were enrolled in the program and received EBSE services. During that time, 32% of the enrollees worked in a competitive jobs which resulted in over 17,000 days of employment during the 6 month period from September 1, 2006 to March 31, 2007 and, with the 187 additional enrollees in the following quarter, persons enrolled in EBSE held a competitive job for 19,159 days between April 1 and June 30, 2007. The DMH tracks employment status of adults seeking community mental health services on an on-going basis (**see system performance indicators A1.4 and A1.5**).

A grant-funded project which addressed both housing and employment, The Corporation for Supportive Housing - Stepping Up Strategy Panel, was a Department of Labor (DOL) grant to develop career ladders for supported housing tenants who are employed and in poverty. The DRS has worked with the DOL and Wright City College to develop supported education, job placement, and support opportunities for persons with severe mental illnesses and other disabilities in the Chicago area that have trouble maintaining stable housing. Although the five year grant ended in September, 2007, it resulted in a curriculum developed by Wright City College to support career development which can be disseminated for use in community colleges.

## **Housing Services for Adults**

Illinois has been consistent in its efforts to develop housing options and support services for consumers of mental health services. Substantial portions of block grant funding are allocated for the provision of ‘therapeutic’ Supervised and Supportive Residential Services Programs. Community supports range from in-home help for families, to community integrated living arrangements where people share a home with services individually tailored to their needs, or independent apartments with support services. Supported and Supervised Residential programs offer skills training, counseling and

other supports to assist our consumers in maintaining a stable living arrangement. The next step for Illinois is to expand resources in the creation of Permanent Supportive Housing. See Section III-A for a full review of the initiative and the objectives for FY2009. Housing status is tracked on an on-going basis by DMH (see system performance indicators A1.6 and A4.1).

In addition to this initiative, the Illinois Legislature has steadily increased the State's commitment to housing for persons with mental illnesses since FY2005, when DMH first received an allocation of \$4.7 million for "Mentally Ill Supportive Housing". That year, the DMH contracted with 34 community-based agencies to serve 1,232 persons with disabilities, who were formerly homeless, to provide affordable housing and supportive services. In FY 2006, the appropriation by the Legislature brought the total allocation to \$6,150,000, which led contracts to another 13 providers for new supportive housing opportunities to an additional 279 individuals. In FY 2007, another \$4.3 million was added bringing the total appropriation for that year to \$10.5 million funding 11 new supportive housing projects that served another 134 consumers. In FY2008, an additional \$3.9 million was allocated bringing this initiative to a projected \$14.5 million, adding 12 additional supportive housing projects statewide, and serving 263 new consumers.

### **Educational Services**

Educational services in the form of stipends and scholarships for college, trade school, and vocational training are available through DRS and facilitated by mental health providers. Consumers receive support through Psychosocial Rehabilitation and Care Management in pursuing the completion of basic educational requirements (e.g., GED) and other available educational programs through local public school system. Since FY2005, DMH has continued to emphasize consumer and family education and this will continue in FY2009 through a variety of educational activities. A law enacted last year establishes statewide uniformity in the School Code for students with disabilities who are now eligible to receive special education services up until the day of their 22nd birthday. This is particularly helpful to transitioning youth.

### **Substance Abuse Services**

Services for individuals with substance use problems are provided by community-based substance abuse treatment programs which are funded through the DHS Division of Alcoholism and Substance Abuse (DASA). These programs provide a full continuum of treatment including outpatient and residential programs for persons addicted to alcohol and other drugs.

### **Services for Co-Occurring Substance Abuse and Mental Health Disorder (MISA)**

Many adults with serious mental illnesses have co-occurring mental health and substance abuse disorders. In Illinois, substance abuse, particularly, has been a primary presenting problem for nearly half of the individuals admitted for treatment in DMH state hospitals. Although data submitted by providers to the DMH reporting of community services (ROCS) system showed that close to 12% of consumers seeking services having a

co-occurring substance abuse diagnosis (See System Performance Indicator A1.9), research suggests that a much higher proportion of persons with mental illness also have substance use problems. The collaboration of DMH and the DASA to meet the needs of this population were previously described (Section I). In respect to service provision, DMH and DASA continue to work with the five geographic MISA consortiums that were established in FY 2003 which meet quarterly at a minimum to problem-solve and develop strategies to meet the needs of individuals with co-occurring disorders. Collaboration has continued on co-location projects in which DASA funded agencies work on site at DMH state hospitals to assess, consult and transition consumers with co-occurring disorders to appropriate community-based mental health and substance abuse services.

In FY2007, the Division of Mental Health completed its work on a three year Training and Evaluation grant funded by SAMHSA CMHS. Training and evaluation in the IDDT model were provided to nineteen agencies (17 community-based agencies and 2 state hospitals) located in Chicago. The IDDT project used the Integrated Dual Diagnosis Treatment Fidelity Scale, a component of the IDDT Resource Implementation Kit published by SAMHSA, and added the Dual Diagnosis Capable in Addiction Treatment (DD-CAT) Scale developed by Mark McGovern from Dartmouth University. Both instruments provided the IDDT project with the opportunity to assess agency capabilities to improve and to provide integrated treatment services. Participating agencies were provided with tailored technical assistance and consultation geared toward strengthening each agency's ability to move toward providing IDDT. Agencies used the opportunity to assess their capability to commit to implementation of the IDDT model or to move forward with the necessary changes that would enhance their capability to provide IDDT services. In FY2007, the project conducted 35 training sessions and 103 individualized consultations and technical assistance visits aimed at increasing agency capability to treat clients with co-occurring disorders. Three agencies began the process of implementing IDDT, six agencies used the Dual Diagnosis Capability in Addiction Treatment (DDCAT) scale to improve their capability and are now considered to be in the Dual Diagnosis Capable range, and one agency became Dual Diagnosis Enhanced. The IDDT project emphasized statewide education and leadership to promote IDDT. By the end of the project, it was conclusively established that consultation and technical assistance are the key means of strengthening the ability of agencies to move toward providing Integrated Dual Diagnosis Treatment services. The feasibility of realigning these activities with new funding is currently being assessed.

### **Medical and Dental Services**

Adults with serious mental illnesses access the same medical and dental care services available to the general population through the service coordination functions provided in case management and therapeutic services. DMH is addressing issues in primary health care with a special emphasis on the relationship between primary health care and mental illness. Adults with mental illnesses often have neither the insurance nor the financial means to cover their healthcare costs. Assistance is usually provided to them in applying for Medicaid. Those who are Medicaid eligible benefit from the medical services and programs provided through the Department of Healthcare and Family Services (DHFS) which were described above. For hospitalized patients, this process is begun as close to admission as possible.

In addition to treating consumers for their acute psychiatric conditions, DMH state hospitals employ primary care physicians who provide basic general health care. All State Hospitals are required to provide dental screening exams and basic dental care to their inpatients. They do so either by directly employing dentists who work at the hospitals or via a contractual arrangement with an independent provider. Metabolic Syndrome screens are provided in state hospitals to identify individuals who may have Diabetes.

Integration of primary medical care and behavioral health care is increasing in importance and is being energized by federal funding initiatives. DMH staff continue to explore options for collaboration with Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers (FQHCs) in Illinois. The DMH Central Region has actively facilitated dialogue and collaboration between CMHCs and the FQHCs in that Region of the state. Several CMHC'S have participated in this collaboration in the past three years. In FY2008, DMH partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in applying for and obtaining a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provides \$2 million over a two year period to improve access to, and quality of, primary health care services through peer-delivered crisis response services. Through the grant, two new Community Health Center (CHC) sites will be located on or near hospital campuses which will partner with behavioral health providers so consumers seeking non-emergent care may be seen in a non-emergent primary care and behavioral health setting. DHFS will seek proposals from CHC/hospital and behavioral health collaborators and will fund two collaborations, one in Chicago and one in an area serving rural citizens.

## **Support Services**

Effective mental health services across Illinois require the integration of local community-based services from a variety of sources. The development of local networks of service providers has been instrumental to improve this integration. Many of the local networks have representatives from local housing, public health, vocational development, and medical care as a part of their memberships.

IDHS provides an extensive range of services that are available to adults with serious mental illnesses. Liaisons have been developed between local community mental health centers and local IDHS offices for the purpose of facilitating consumer entitlements and identifying those IDHS clients who are in need of assistance in accessing mental health services.

The Home-Based Support Services Program, which is legislatively mandated, provides reimbursement for support services to adults with serious mental illnesses (SMI) or DD; requests for services must be approved by a Service Facilitator and by IDHS program staff. The statute requires SSI/SSDI disability status as a condition of application and states that these program resources are not intended for any services which are available

through other programs or entitlements. Selection for the program is by application and random selection. The program currently serves 213 adults with SMI.

GAPS Work Incentive and Planning Assistance Project. To assist mental health consumers and other individuals with disabilities, DMH applied for and received the Work Incentives Planning and Assistance grant funded by the Social Security Administration, which began in October 2006. This cooperative agreement funds benefits planning and assistance for persons with disabilities receiving SSI/SSDI and their beneficiaries. The primary goals of the project are to provide (1) accurate information regarding state and federal benefit and work incentive programs; (2) assistance in interpreting and applying this information so that they can make informed decisions regarding employment; (3) to provide technical assistance on benefit planning strategies to service providers and advocates working with persons with disabilities; and, (4) activities with SSI/SSDI recipients regarding the availability of benefits planning and assistance services presented in "lay terms" that are non-technical and culturally sensitive. DMH Work Incentive Planning Assistance (WIPA) services are being provided to persons in suburban Cook County and more than 40 counties across Illinois.

### **Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)**

Local school systems provide special education and a range of related support services to students with disabilities over the age of 18. Mental health and transitional services include but are not limited to counseling, adapted driver education, parent counseling, psychiatric, psychological and social work services, behavioral intervention planning, transitional services through the STEP program, career and technical education, competitive and supportive employment, interagency linkages for social services, and supports for transition to post-secondary (college) education. Since the same student can use several services, the Illinois State Board of Education (ISBE) uses a point-in-time count to reach an unduplicated total. Based on the data provided by local school districts for the 2005-2006 school year, as of December 1, 2005, at least one of the above services was provided to 1517 students in the Emotional Disability category who were over the age of 18 years, 277 such students in the Autism category, and 58 students over 18 in the TBI Disability category.

### **Case Management Services**

In Illinois, Case Management is a required service for adults with serious mental illnesses who receive substantial services through the public mental health system. It is pivotal to hospital-community linkages and in providing continuity of treatment and supportive services in the community. Due to DMH's early adoption of the Community Support Program and CASSP models, for which Case Management is the critical "hub of the wheel" of services, Case Management services have been continually available in Illinois as a core service, and efforts are made to track service delivery on an on-going basis (**see system performance indicators A1.10—and A1.11**). Continuity of Care Agreements (COCAs) between community mental health providers and state hospitals outline assurances of coordinated service approaches by clinicians from both settings who are knowledgeable and attuned to the needs, strengths, and weaknesses of the consumer, the

consumers' support networks, and the environment. It is required that care management assignments be solidified during the inpatient treatment process, with face-to-face linkage occurring within seven days post discharge. Compliance with the COCA requirements in discharge, linkage, and face-to-face engagement is monitored by CCSR. Increasing the availability of services to support continuity of care for persons discharged or triaged from state hospitals and increasing the capacity of ACT programming through Medicaid Reimbursements have been priorities in recent years. Two types of case management services assure continuity of care tailored to individual needs:

- **Case Management** includes a variety of case management programs for consumers with special needs (e.g. hearing impaired, homeless, dually diagnosed etc.) and other consumers identified as requiring ongoing support, coordination of multiple service providers, and periodic outreach to maintain service linkage and stability in their community. Clients are provided with identified persons who maintain supportive contact, help them with practical problems, and assist them in accessing services.
- **Assertive Community Treatment (ACT)** is most intensive specialized model of service whereby a tightly-knit team of mental health professionals takes full responsibility for a small group of adult clients' day-to-day living and treatment needs.

Both these levels of case management provide sustaining services and activities including assertive outreach, sustained efforts to engage individuals, assessment, planning, linkage, advocacy, and assistance with basic needs which include decent housing, income, and medical benefits.

### **Community Support Teams**

The Community Support Team (CST) model was established by DMH in FY2008 as a core service to support recovery/resilience. The Community Support Model is based on a set of recovery supportive activities and interventions that may be delivered in a highly flexible range of intensity of service, frequency, and modalities including individual, group, and team. Illinois defines community support as consisting of the mental health rehabilitation interventions and supports necessary to assist the individual in achieving rehabilitative, resiliency, and recovery goals....designed to meet the educational, vocational, residential, mental health, co-occurring disorders....financial, social, and other treatment support needs of the individual. Interventions and activities are delivered in natural settings and are targeted toward the management and reductions of symptoms as well as the promotion of stability and independence. Community Support is seen as an active intervention which builds capacity by assisting the individual to do for self.

Reimbursement is based on medical necessity which includes documentation of psychiatric disability (diagnosis), currently assessed need, an existing service plan with allowed interventions, and a continuing assessment of progress toward achieving recovery/resilience goals.

Community Support Team services consist of therapeutic interventions delivered by a team that facilitates illness self-management, skill building, identification and use of natural supports, and use of community resources aimed at decreasing hospitalization and crisis episodes and increasing community functioning in order for the consumer to

achieve rehabilitative, resiliency and recovery goals. CST services can be provided face-to-face, by telephone or by video conference to an individual or family member; Providers are required to deliver 60% of all CST services in natural settings, during times and at locations that reasonably accommodate the consumer's needs, and at hours that do not interfere with the consumer's work, educational and other community activities;

Individuals eligible for CST services are those who require team-based outreach and support for their moderate to severe mental health symptoms and who, with such coordinated clinical and rehabilitative support, may access and benefit from a traditional array of psychiatric services. A less intensive service must have been tried and failed or must have been considered and found inappropriate.

The CST Team must maintain a client-to-staff ratio of no more than 18 clients per full time equivalent staff; be able to demonstrate that more than one member of the team is actively engaged in the direct service to the individual, and conduct organizational staff meetings at least one time per week at regularly scheduled times. The Team is composed of a full-time team leader who is at least a QMHP and serves as the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; a Rehabilitative Services Associate or Mental Health Practitioner who works under the supervision of the QMHP, and an individual in recovery from mental illness, preferably a Certified Recovery Support Specialist (CRSS) or Family Resource Developer (FRD) who is a fully integrated CST member who provides consultation to the team and highly individualized services in the community, and who promotes self-determination and decision making. A Team must consist of no fewer than 3 full-time equivalent staff meeting the required team components (including the team leader) and no more than 6 full-time equivalent staff or 8 different staff.

### **Other Activities Leading To the Reduction of Hospitalization**

#### ***Historical Reduction of State Hospitals Beds and change in the Utilization of Psychiatric Inpatient Care***

Illinois has shared the de-institutionalization experience common throughout the U.S. over the past three decades, including the closure of large state hospitals and the dramatic downsizing of the remaining large older institutions. At the height of the era of institutions in 1940, Illinois state hospitals had a resident population of 55,587. In contrast, the resident population on June 30,2008 was 1,353. Significant decreases of admissions in state hospitals are the result of attention to the issue of local area utilization of state hospital resources and continuity of care. The statewide reduction of bed utilization is based upon the principle that reduction must occur within a context that assures that clinically effective care remains continuous and that alternative and supportive community services are in place.

A variety of strategies have resulted in a significant reduction in admissions to state hospitals from 21,393 adults in FY1987 to 10,729 in FY2008. The reduction in admissions has allowed a reduction in the size of all facilities and closure of several with the concomitant increase in the provision of services in the community to persons who

would otherwise have been hospitalized in state hospitals. Paralleling the downsizing of state hospitals, and fostering the movement to the community, Illinois has developed a network of community mental health agencies covering all geographic areas of the State. These providers share the goal of providing the necessary basic services to maintain persons with serious mental illness in the least restrictive setting possible. The reduction in admissions and bed utilization since FY1993 has largely been the result of a continuing impact of a succession of new initiatives.

- **Single Point of Responsibility** for screening of admissions to state hospitals has had the broadest impact in significantly reducing the rate of hospitalization. In FY-1993, Illinois developed a re-conceptualized system for Single Point of Responsibility referred to as Pre-Admission Screening, which was implemented across the State and has consistently resulted in over 90% compliance over the past several years.
- **Community Based Programs for High Users:** High users (3+ admissions in a year) of psychiatric hospitalization have been targeted since FY1994 through the implementation of ACT teams in the geographic areas that have the highest concentration of heavy utilization.
- **Building Community Services:** Several initiatives have had a substantial and sustained impact on the public mental health system of care. In FY1997 through an initial appropriation of \$7,249,000 in General Revenue Funds (GRF), a system of hospital admission screening, linkage case management, intensive case management, Assertive Community Treatment (ACT), and crisis services were expanded in order to intensify community supports. Each Comprehensive Community Region (CCSR) now ensures that a community mental health provider screens consumers prior to admission to state hospitals. When consumers are discharged or triaged from a state hospital they are enrolled with a care management provider to assure linkage to needed treatment and support services. Reductions in state hospital utilization have resulted in funds becoming available for the development of community-based services designed to maintain individuals in the community and to provide inpatient services when required in community hospitals.
- **Entitlements.** A significant factor in avoiding re-hospitalization is assuring the availability of medical and financial support to consumers upon their discharge from the state hospital. DMH has instituted policies to ensure that state hospital staff work with individuals to determine their potential eligibility for Medicaid services and expedite the process to increase consumer access to medical benefits upon discharge from the state hospital. Community mental health agency staff also work with consumers around this issue. There has also been increasing focus on Medicaid eligibility as the DMH payment system transitions from grant-in-aid funding to fee-for-service.

The trend for reduced rates in admissions and census has begun to reverse over the last few years. The number of adults (non-Forensic) admitted to state hospitals in FY2005 was 9,462, a slight increase from that seen in FY2004. In FY2007, there were 10,668 civil admissions to state hospitals and in FY2008 there were 10,139 admissions. The median length of stay for the same population has steadily decreased from 19 days in

FY2000 to 11 days in FY2008. At the present time, all civil state hospitals are quite small, with some having a census of less than 100, and the largest being under 150. For both admissions per 100,000 and beds per 100,000, this places Illinois below the U.S. average.

### ***Services for Persons Involved In the Criminal Justice System***

The incarceration of persons with serious mental illness in correctional settings continues to be a matter of increasing concern in Illinois. The DMH serves a forensic population consisting of individuals determined by the court to be unfit to stand trial (UST) or not guilty by reason of insanity (NGRI). According to data reported by DMH community providers, approximately 2% of persons with mental illness seen at intake are forensic outpatients, and about 2% have a correctional history. These figures are fairly low. However, mental health staff has estimated that about 10,000 persons with mental illness are served annually by Creak Hospital at Cook County jail – more than the total number of people served annually by all the Illinois state hospitals combined. This high incidence is part of a continuing and larger national trend for persons with mental illnesses to comprise an increasing proportion of prison inmates and jail detainees. The DMH tracks key system performance indicators related to criminal justice involvement on an on-going basis (**see system performance indicators A.1.7 and A.1.8**). The DMH has implemented a number of initiatives related to the criminal justice system with key stakeholders in order to address concerns regarding the large number of individuals with mental health needs who are involved with the criminal justice system. These include the Jail Data Link Program and the mental health court collaboration in Rockford that includes diversion, discharge planning and service linkage to Janet Wattles Community Mental Health Center. These programs were described in Section I and they will be highlighted in Section III of the application.

Forensic Services oversees and coordinates all forensic mental health services for the Department of Human Services - Division of Mental Health. A primary responsibility of Forensic Services is coordinating the inpatient and outpatient placements of adults and juveniles remanded by Illinois County Courts to the Department of Human Services under Statutes finding them Unfit to Stand Trial (UST) (725 ILCS, 104 -16) and Not Guilty by Reason of Insanity (NGRI) (730 ILCS, 5/5-2-4). The DMH operates programs for forensic patients at five state hospitals. The forensic population includes those persons determined by the court to be unfit to stand trial (UST) or not guilty by reason of insanity (NGRI). In an effort to ensure continuity of care when these individuals are discharged from state services, DMH Forensic staff provide consultation to community agencies that provide mental health services. DMH staff monitor the services and activities of conditional releases through contacts with community mental health service providers. DMH continues to take an active role in collaborating with the Illinois Sheriffs' Association to work on areas of mutual concern identified through surveys and discussion with Association members.

- Collaborative initiatives which respond to ongoing consumer needs such as work with the criminal justice system, with providers of alcoholism and substance

abuse services, with providers of vocational and employment services, and the Department on Aging on the mental health needs of older persons must continue as a priority.

- Maintaining and enhancing activities aimed at reducing hospitalization such as crisis services, face-to-face screening prior to hospital admission, case management services, including the ACT program community support , and the development of community-based resources for ongoing clinical care and supportive services in the community remain an important DMH priority.

## **Criterion 2: Mental Health System Data Epidemiology**

### **INDIVIDUALS RECEIVING PUBLICLY FUNDED SERVICES**

#### **Prevalence Estimate**

The CMHS definition and methodology for prevalence estimation for adults is published in final notice form in the Federal Register Volume 64, Number 121, June 24, 1999. The methodology provides a calibrated point estimate of the 12 month number of persons who have Serious Mental Illness, age 18 and older in Illinois. This does not include persons who are homeless and institutionalized.

The prevalence estimate provided by CMHS is 5.4%. Based on the adult population for Illinois, it is estimated that in FY2008 there were 519,421 adults with serious mental illnesses residing in Illinois.

#### **Definitions of DMH Population Eligible to Receive Services**

Descriptive eligibility criteria for core services provided in the Illinois public mental health system have been developed and specified using certain broad clinical-diagnostic categories as well as more specific indicators of need. Two groups of consumers are the focus for service provision: a larger “eligible” group and a smaller “target” group. Persons who fall in the eligible group meet a minimum criteria of mental illness or emotional disorder as well as significant impairment in life functioning and may be served in the Illinois system. Individuals who are considered part of the “target” population meet a much stricter and more debilitating level of mental illness and impairment and must be served. The CMHS prevalence estimation methodology seems to overlap the target and eligible population definitions that are currently used by the DMH. While there is a substantive gap between the total prevalence and the annual numbers served, we know that a certain percentage of these individuals may not need or request service in a particular year and an unknown proportion of those who do need service may be served in the private sector. Estimating the size of the non-served portion of the total estimated prevalence is contingent upon the availability of utilization data for privately provided psychiatric services which is not currently available.

## **Definitions of DMH Eligible and Target Populations**

### **The Eligible Population (Adults and Children/Adolescents):**

- Must have a mental illness, defined as “a mental or emotional disorder verified by diagnosis contained in the DSM-IV or ICD9-CM which substantially impairs the person’s cognitive, emotional and/or behavioral functioning, excluding the following unless they co-occur with a diagnosed mental illness: V-codes, organic disorders, psychoactive substance induced organic mental disorders, mental retardation, pervasive developmental disorders associated with mental retardation, and psychoactive substance use disorders.
- Must have significant impairment in an important area of life functioning as a result of the mental disorder identified above and as indicated on the Global Level of Functioning (GAF) for adults and Children’s Global Assessment Scale (CGAS) for children.
- All ages

### **The Adult Target Population:**

- Must be 18 years of age or older.
- Must have a *serious mental illness* (SMI) defined as, “emotional or behavioral functioning so impaired as to interfere with their capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of their capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental impairment may limit their ability to seek or receive local, state, or federal assistance with housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services”.

## **Demographic Factors**

In Illinois, three major ethnic and racial minority groups represent over 30% of the total population – 15.1% African Americans; 12.3% Hispanic Americans; and 3.4 % Asian American/Pacific Islanders. The DMH Bureau of Decision Support, Evaluation and Research continues to evaluate access and utilization of mental health services by specific ethnic groups using data such as that generated for URS Tables 2A and 2B. In recent years, the IDHS has also focused on the segment of the state’s population, which remains uninsured or under insured without sufficient resources to purchase needed mental health services. An increasingly accepted guide for identifying this segment is the utilization of the 200% poverty level which provides census-based demographic data which assists in targeting service delivery and developing cost models which support a system of care for the neediest persons in the State.

## **Individuals Receiving Services In FY2008**

Information on the number of persons served in FY2008 is derived from Basic Tables 2A and 2B, which is being prepared for the FY 2008 Uniform Reporting System Tables.

National Outcome Measures (NOMs)/Performance Indicators with quantitative targets related to increased access to services are described at the end of Section III.

The number of individuals with Serious Mental Illnesses (DMH eligible population) reported as receiving services from DMH-funded agencies in FY2007 was 132,787, approximately 94% of the total number of adults receiving services. FY2008 data is currently being gathered.

### **Progress In Performance Measurement**

The DMH has established reporting requirements and standards for data submission that are incorporated in all DMH funded agencies contracts. Data is submitted to the Reporting of Community Services (ROCS) information system. All data is submitted electronically using one of two mechanisms: (1) DMH developed software -- Reporting of Community Services (ROCS) is available at no cost to community providers or (2) Third Party proprietary software purchased directly from a vendor by community providers. If proprietary software is used, data must be submitted using data reporting standards developed by DMH. DMH regularly obtains downloads from the Illinois Medicaid agency. These service claims data are routinely integrated with the reporting of services otherwise funded by the DMH. Case registration data fields that are part of DMH reporting requirements are formatted to permit integration and matching across services funded by the DMH and the DDD, and they lay the groundwork for future matching with other state agencies, including the DASA, the DRS. Assessments are routinely undertaken to determine when new data elements to support decision-making should be added and when others should be eliminated. DMH has made several modifications over the last few years to enhance data collection requirements and to permit collection of data that is compatible with Uniform Reporting System requirements as developed under the State Infrastructure Grants (DIGs). DMH reporting standards require full reporting of consumer and service data by community providers. Data for consumers receiving treatment in DMH state hospitals are also reported electronically to the DMH Clinical Information System (CIS).

DMH, working with the Illinois Mental Health Collaborative for Access and Choice (MHCAC), has redesigned and is implementing a new management information system (MIS). This work includes the development of a data warehouse that will house eligibility, registration, billing/services information, a provider database, and service authorization in one place. DMH will have unprecedented access to this data. One of the updates to the MIS is the requirement to update key clinical and demographic fields that will be used to track consumer outcomes over time.

### ***Unduplicating Clients and Tracking Services Across Systems.***

Beginning in FY2006, in preparation for the move to a fee-for-service payment system, all individuals seeking mental health services have been assigned unique ID numbers referred to as RINS. RINS are also being assigned to consumers who access services under other Divisions within DHS, as well as to individuals receiving services through the Child Welfare System and Corrections. The RINS will lead to improved tracking of services received by consumers across state systems, as well as increased accuracy in unduplication of consumers receiving services in the mental health system.

### ***Performance Measurement***

Data reported to the ROCS and the CIS are used as the basis for computing performance indicators that have been established by DMH to monitor system performance. Information is disseminated to a wide variety of entities in different formats that have been designed to be user-friendly. Through the use of quantitative measures of organizational functioning, comparisons can be made against a standard over extended time or between organizational units. Target levels for the performance indicators provide focus for evaluation and planning.

DMH staff have successfully participated in federally funded studies and activities related to performance measurement, including the Data Infrastructure Grant opportunities over the years. This included piloting the implementation of MHSIP Consumer Oriented Mental Health Report Card performance measures, the Five State Feasibility Study of Performance Measurement, the Sixteen State Pilot Indicator Study on Mental Health Performance Measures, the State Data Infrastructure Grants, and the current State Data Infrastructure Grants for Quality Improvement.

### **CRITERION 4: Targeted Services To Homeless, Rural, and Elderly Populations.**

*This section describes services to the homeless, rural and elderly populations in Illinois, related service system initiatives, and concludes with some analysis of the system's strengths, needs and priorities.*

#### **The Homeless Population in Illinois**

The most reliable source, though not complete, for descriptive data of the homeless population is the IDHS Division of Human Capitol Development, Office of Family Support Services, which administers the Emergency Food and Shelter (EF&S) program. This program was developed to provide immediate food and shelter to homeless persons and families or persons and families at imminent risk of becoming homeless. It provides meals, beds and supportive services through not-for-profit organizations to homeless individuals and families to assist them to return to self-sufficiency. The General Revenue Fund (GRF) allocation for the EF&S Program in FY2007 totaled approximately \$8.5 million. Between July 1, 2006 and June 30, 2007 there were 47,697 individuals that received shelter, food, and services to meet their emergency needs and help them regain self-sufficiency. During the year, organizations funded through the EF&S Program provided 2,078,867 nights of shelter, served 2, 963,275 meals and delivered 2,474,881 units of supportive services.

The IDHS Emergency Food and Shelter (EF&S) program issues an annual report that reviews trends in services provided to homeless persons in Illinois. *The data should not be construed to represent the total homeless population in Illinois, because not all homeless persons are served by the EF&S program.* Several trends in the characteristics

of the population have been noted within recent years. Homelessness is affecting fewer people, becoming more rural, occurring in a younger population, and there is a significant percentage of homeless individuals who have a disability.

### **The FY2007 Report**

The most recent report by EF&S (FY2007) provides an interesting profile of the homeless population receiving services<sup>1</sup>. The number of participants in the program decreased slightly (3%) from 49,150 in FY2006 to 47,697 in FY2007. Sixty percent of the participants in FY2007 were males. There were 33,223 total households (the measurable unit of family composition) and, of these, single males comprised 20,816 households and single females, 5,660. The remainder were: couples with no children (247), couples with children (700), a single male with children (201) and a single female with children (5,599).

In FY2007, the racial composition of the homeless population served by EF&S consisted of 62.5 percent African American and 29 percent European-American. The other categories tracked: Hispanic or Latino (3,470), American Indian/ Alaskan Native/Pacific Islander/Asian (1031), and Other Race (3,083) accounted for the remaining 8.5%.

The 6,500 households with children noted above accounted for 13,224 participants under the age of 18 (27.7% of the total served) of which 50% (6,569) ranged from newborn infants through five years of age. Combined with the 18 through 21 year old group (2,697) 33.4% of the homeless persons served by the EF&S program were under the age of 22. In comparison, only 2.1% of those served (1,002) were over the age of 62 while those 41-61 (34%) and those 22-40 (30%) were similar in numbers which dispels the myth that homelessness is predominantly an issue for older adults.

This is consistent with the finding that the major causes of homelessness are identified as income and family/neighborhood issues which have the most impact on households with children. Of the 33,223 households served by EF&S in FY2007, the largest group, 38 percent (12,711) cited income as the primary cause of their homelessness. Insufficient income, loss of job, loss of public assistance, and mismanagement of money were reasons given on this category. Another 20 percent (6,778) gave reasons related to family and neighborhood such as overcrowded conditions, domestic violence, gang violence, and disputes with neighbors and landlords. The remaining 42% cited the lack of affordable and decent housing, alcohol and substance abuse, medical problems, release from correctional facilities, and relocation as primary reasons for being homeless.

---

<sup>1</sup> For services in Chicago, the IDHS contracts with the Chicago Department of Human Services (CDHS). The CDHS uses non-profit organizations to provide food, shelter, and supportive services to homeless individuals and families within the city. The CDHS has oversight for organizations, monitors services, vouchers funds, reports to the Department and operates an emergency call system. The appropriation for EF&S is divided between Chicago (53%) and the remainder of the state (47%). CDHS combines EF&S funds with federal and municipal money. The EF&S program funded 42 projects in Chicago through 22 providers in FY2007. Data submitted by CDHS is included in the annual report. However, CDHS does not report on length of stay in shelters for all entrants and shelters' refusal and referral data.

Forty-four percent (44%) of adults served by the EF&S program reported a disability in FY2007 (21,273 of 47,697). Substance abuse and alcohol abuse continued as the most common reported disabilities.. Mental illness comprised 16% of the disabilities reported in FY2007 and was reported by 7% (3,334) of the total number of persons served. In FY2007,it was the third most prevalent disability after 22% (10,582) reported substance and/or alcohol abuse and 11% (5, 246) reported a physical disability .

### **Outreach and Services to Homeless Adults**

Homeless adults with serious mental illnesses require linkage to outpatient and inpatient mental health services and to housing, employment, and other support services. The DMH has encouraged providers to develop working relationships and working agreements with neighboring shelters, soup kitchens and pantries in order to identify where outreach and engagement service needs were to be focused and to develop co-affiliation services for this population. The DMH continues to undertake efforts to provide intensive outreach to this population. Resources have been shifted to create additional case management positions to work with homeless individuals who present at sixteen homeless shelters across the Chicago area.

#### ***Project for Assistance in Transition from Homelessness (PATH)***

Illinois has a history of working with homeless persons. Since 1988, Illinois has been a recipient of the former S.B.McKinney federal funding through the Department of Health and Human Services, Center for Mental Health Services, Project for Assistance in Transition from Homelessness (PATH) programs. These specialized services target individuals who are homeless or at risk of homelessness with serious mental illnesses or homeless with serious mental illnesses and co-occurring alcohol and substance abuse problems. In Illinois, providers have developed an array of services that include in vivo case management, a drop-in-center, transitional residential support service, and a mobile assessment unit in Chicago. Yearly increases in Illinois' PATH allocations have been used to expand and enhance services to homeless persons with mental illness.

### **Rural Mental Health Services for Adults**

#### ***Definition of "rural localities" in the State***

In Illinois, the definition of rural has been based upon the U.S. Bureau of the Census designation of Metropolitan Statistical Areas (MSA) which are assigned to counties that contain a central city or twin cities having a population of 50,000 or more. The classification of counties into MSA (metro) and non-MSA (non-metro) categories has been found to be the best and most common way to define urban and rural. Thus, the term "rural" in Illinois is used to refer to residents in 76 non-MSA counties and residents not in municipalities of 25,000 or larger. (Rural Revitalization: The Comprehensive State Policy For the Future, Governor's Rural Affairs Council, April, 1990 pp. 2-4) Based on Illinois' definition of rural areas, 76 non-metropolitan counties are being targeted for assessment of the mental health needs of residents, evaluation of current services and programs, and the identification and eventual resolution of problems in service delivery unique to rural environments.

The DMH is a member of the Governor's Rural Affairs Council and provides the mental health perspective on rural issues. The Council provides an opportunity to network with a variety of state government agencies and community institutions, which can support mental health services in rural areas.

Public Act 95-16 signed by the Governor in July, 2007 gives Illinoisans living in rural communities increased access to psychiatric care by requiring the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via telepsychiatry, e.g.; videoconferencing. Individuals needing quality mental health care who live long distances from mental health providers can get the help they need through technology advances which helps in addressing the shortage of psychiatrists working in rural communities.

### ***Mental Health Services in Rural Areas***

Mental health services for persons with serious mental illnesses are available in rural Illinois through hospital programs and community mental health centers. The DMH provides grant funding to community mental health centers, certifies mental health centers for Medicaid Clinic, Rehabilitation, and Case Management options and provides Emergency Psychiatric Services funds, which can purchase emergency services through a community clinic or private psychiatric hospital. DMH providers offer crisis/emergency services, outpatient services including psychiatric services, care management, PSR, and residential services in rural areas across the state.

Since FY1997, the Comprehensive Community Service Regions (CCSR) serving Greater Illinois have worked on enhancing and developing core mental health services for adults with serious mental illness residing in rural areas. CCSR staff work closely with mental health providers serving the more sparsely populated rural areas to design services which are as accessible as possible and allow for a range of services to meet the treatment and support needs of rural residents as effectively as possible.

The DMH has conducted surveys of mental health needs in rural areas and subsequently developed a *Rural Mental Health Technical Assistance Resource Packet* for rural mental health providers and consumer leaders, which was disseminated to over 100 providers. While the DMH has been responsive to many of the concerns identified in the surveys, family education and self help resources continue to be under-supplied and there continues to be an overall access problem, especially with regard to psychiatric services. Major concerns across rural counties include the need for transportation and for "one-stop" services shopping. These concerns suggest the need for a broader partnership among state agencies.

### ***Expansion of Services for Older Persons Residing in Rural Areas***

In rural areas, the older population often experiences the most difficulty in obtaining services that are geared to their needs. The Geropsychiatric Initiative, initiated by the DOA and DMH in FY 2001, is designed to meet that need and was piloted in the rural areas in DMH Southern and Metro-East Regions. Local coordinating councils have been established for all 27 counties in the pilot project service area. The primary purpose of

these councils is to educate key stakeholders regarding services available, the process for accessing services, and identifying strategies for improving services. The councils include representatives from primary health care, consumers, aging area offices, mental health agencies, and senior citizen centers. Each Community Mental Health Center has a case manager assigned specifically to focus on service provision for older adults.

### **Services to Older Adults**

More than 1.9 million persons over the age of 60 reside in Illinois, representing nearly 20% of the state population. It is conservatively estimated that 15-25% of individuals over age 60 experience symptoms of mental disorders as they are considered to have a higher incidence than other age groups due to increasing number of life stressors. While older adults may be more vulnerable to experiencing mental health problems, they often do not seek, or are not successful, at linking with needed mental health services. In FY2007, a total of 7,095 individuals over the age of 65 were served , accounting for only 4% of the total number of individuals served. Several systems of care play a role in the delivery of mental health services to the older adult including mental health, aging, primary medical care, and public health. In recognition of the importance of coordinating services for this population, DMH jointly coordinates an Advisory Committee on Geriatric Services with the Illinois Department on Aging (IDOA). This Advisory Committee has focused its efforts on the assessment of the mental health needs of the elderly, identification of model programs, best practices and staff competencies, and increased awareness of geriatric mental health concerns. Training, consultation, and technical assistance in the area of mental health and aging continue to be provided through the efforts of the Advisory Committee. Recent developments in this on-going collaboration are discussed further in Section III.

### **Geropsychiatry Services**

This mental health and aging systems initiative establishes a geropsychiatric specialist in a comprehensive community mental health center with access to a psychiatrist, board certified in Geropsychiatry, to improve access, availability and quality of mental health services for older adults (age 60 and older) with mental health needs. The program strives to positively enhance integration of mental health, aging, primary medical care and public health systems to enhance the effectiveness of mental health service delivery to this population. The Geropsychiatric Initiative focuses on three key areas: systems integration, mental health services/consultation and training/education. In FY 2007 there were five funded positions for Geriatric Specialists that cover 27 counties throughout the southern part of the state. However, Geriatric Specialists provided treatment and education resources for mental health services to the aging throughout the state. The GeroPsychiatry Initiative has received national recognition. In 2005, it received the American Society on Aging/Pfizer Award of Excellence---the only mental health program which ever received this award. In 2006, it was recognized as an exemplary program by the National Technical Assistance Center for Older Adult, Mental Health, and Substance Abuse Services. Statewide expansion of the program has been proposed by the Illinois Department on Aging, but acquisition of sufficient funding continues to be an obstacle to

further development of this valuable resource.

## **Criterion 5. Management Systems**

The DMH continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those responsible for emergency health services regarding mental health. In this section, initiatives to enhance financial resources and human resources including significant achievements are described. There is also a brief analysis of the systems strengths, needs and priorities.

### **ENHANCING FINANCIAL RESOURCES**

#### **Increased Financial Resources For Community Services**

With the increased emphasis on community-based treatment in the last twenty years came an increase in the proportion of budget spending on community mental health services. Compared to 8% of the DMH's budget in FY1973, more than 70% of the mental health budget in FY2008 was allotted to fund community programs.

Since FY1999 the DMH has created a transition line for each state hospital. This funding line can be used for continued state hospital operations if needed, or can be used for expanding community services as census reductions free up resources. In FY2007 \$12,071,107 was allocated in transition funding to the Regions and. \$13,595,067 in FY2008.

#### **Service Enhancement Using Block Grant Funds**

Despite the fact that the allocation of Mental Health Block grant funds to Illinois by SAMHSA has been reduced over the past three years, the DMH continues its efforts to utilize these funds to enhance service provision within the state. Block Grant funds continue to support such initiatives as the provision of wellness, action and recovery planning (WRAP), psychiatric rehabilitation services, residential services and psychiatric leadership services.

#### **Grant Development**

The DMH continues to undertake efforts to increase the flow of Federal and other grant dollars to the state. Some of the grants awarded to DMH over the past few years include the SAMHSA CMHS System of Care Grants (one in Chicago and one in McHenry County), a SAMHSA CMHS evidence-based practices implementation grant for Integrated Dual Diagnosis Treatment, a Data Infrastructure Grant, a SAMHSA Disaster Response grant, a Johnson and Johnson/Dartmouth Grant focusing on Supported Employment, a NIMH Planning Grant to implement Supported Employment, a SAMHSA grant focusing on alternatives to restraint and seclusion, a social security grant related to work incentive planning and a grant funded by the Federal Anti-Drug Abuse Act administered by the Illinois Criminal Justice Authority for the DMH jail data-link project. In FY 2007, the DMH worked with Healthcare and Family Services (HFS) to submit a "Money Follows the Person" grant to the Centers for Medicare and Medicaid Services (CMS). This grant was funded and planning has begun to implement the grant.

In FY2008, DMH partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in applying for and obtaining a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provides \$2 million over a two year period to improve access to, and quality of, primary health care services. DMH was also awarded a SAMHSA Transformation Transfer Initiative grant for \$105,000 which is funding a statewide mental health/criminal justice needs assessment and system mapping initiative.

#### *Increased Financial Resources For The Adult Population*

Financial resources for the adult, as well as the children and adolescent populations come from the General Revenue Funds (GRF) appropriated by the Legislature, Block Grant funds, and the redirection of dollars accrued from the reduced utilization of state hospital services and annualized income from previous initiatives. Through careful planning, previously established initiatives have proven to be beneficial to mental health consumers both in quality of care and increased financial resources.

The Department has requested and received appropriations of General Revenue Funds (GRF) for the continuing expansion and development of Care Management and Crisis Intervention services designed to aggressively promote continuity of care for persons discharged or triaged from state hospitals, Psychosocial Rehabilitation Services (PSR), and to increase service capacity and staff expertise in programs serving persons with dual diagnosis (mental illness and substance abuse).

Since FY 2005, the DMH has received allocations for housing to support persons with mental illnesses. Starting with \$4.7 million in FY2005 additional supportive housing funding was appropriated by the Legislature in FY2006 which brought the total for this specific appropriation to \$6,150,000 and allowed the Department of Human Services and the Division of Mental Health to contract with 13 supportive housing providers for the provision of new supportive housing services to individuals with mental illness who were homeless. In FY2007 an additional \$4.2 million was added to this Supportive Housing appropriation, which addressed the addition of 11 new Division of Mental Health supportive housing projects that provided supportive housing services to 134 consumers receiving services purchased by the Division of Mental Health. In FY2008, an additional \$3.9 million was allocated bringing the total for this initiative to a projected \$14.5 million. These dollars led to the addition of 12 new supportive housing projects statewide, serving 263 new consumers.

#### **Increasing Federal Financial Participation (FFP)**

The DMH has worked closely with CMHCs in an aggressive plan to increase the claiming of federal Medicaid funds to support community based mental health services. Since FY1996 DMH has implemented procedures to increase enrollment and billing of persons leaving state hospitals, and modification of certain technical aspects of the billing process. These activities permitted greater flexibility in generating Medicaid funds for community mental health programs. As a result, there has been a steady increase in the amount of FFP generated to support adult and child and adolescent mental health services in Illinois. In contrast to FY1991, when Medicaid community billing for adult services was \$130,000, Medicaid billing had risen to \$129,028,640 in FY2005. Since then, Medicaid billing has been on an upward trajectory: \$149,599,641 in FY2006,

\$164,742,868 in FY2007 and \$164,407,968 in FY2008.(note: FY2008 figures are preliminary).

## ***ENHANCING HUMAN RESOURCES***

### **Staff Recruitment and Retention**

Human resource development is a critical aspect of community-based services for both adults with serious mental illnesses and children with serious emotional disturbances and their families. It is important to ensure that persons providing mental health services have the required knowledge, skills, competencies and attitudes. In addition, the mental health service system must be able to recruit and retain skilled staff.

There have been several efforts to impact these issues. The continued support of public/academic linkages is one such effort of focus by DMH. All state hospitals in Illinois have agreements with universities to serve as training sites for psychiatric residency programs. These sites provide an opportunity for psychiatric residents to work with patients with serious and persistent mental illnesses, as well as children and adolescents with SED, and to learn how the publicly funded mental health system operates. There are also similar programs with Departments of Social Work, Psychology, and Nursing in universities across the state. These programs provide fertile ground for the recruitment of program graduates who are well grounded in public mental health as a result of their residencies.

FY2008 has been a successful year for the recruitment of key administrative and program management staff by DMH. By the beginning of FY2009 ten new state level staff had been hired into Central Office to oversee sensitive and complex program development functions. See Section I for a broader discussion.

### *Mental Health and Law Enforcement Training*

The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis. DMH, in conjunction with the U.S. Attorney's Office of the Central and Northern Districts of Illinois, has developed initiatives aimed at improving the attitudes of law enforcement and mental health professionals towards each other's views, duties, roles, and skills. DMH has also worked with the Illinois Law Enforcement Training and Standards Board (LETSB) to develop a one-day training program targeted for experienced police officers on dealing with individuals who are mentally ill and in a behavioral crisis. Additionally, a forensic conference 3-Day Conference which attracts a large audience of law enforcement, mental health, and other first responder personnel has been extensively planned in FY2008 and is scheduled for July 15-17, 2008.

### *Training of Providers of Emergency Health Services Regarding Mental Health*

In recognition of the potential for natural or terrorist caused disasters in the State, emphasis in disaster planning has been on developing and/or maintaining a local response capacity. This includes educational offerings and the availability of trained mental health professional and paraprofessional volunteers to respond to the needs of their community in time of crisis. A central list of Illinois mental health professionals who were willing to be deployed on an urgent (surge) basis is continually updated as a resource in the event of

future terrorist aggression or disaster requiring a mental health response. As necessary, the Red Cross may draw down the volunteers in groups. DMH continues to provide training on disaster response in conjunction with other state agencies and entities.

Training in team managed intensive case management has been ongoing in FY2008 with the introduction of the Community Support Teams (CST) and fidelity-related training in ACT.

### ***Human Resource Development Related To The Adult Services***

#### ***The Recovery Vision***

Training events on implementing the Recovery Vision in Illinois continue to be a priority of the DMH. These events are offered statewide, through Regions to providers, consumers, and family members.

#### **. Adults - Strengths, Needs and Priorities for the Mental Health Service System**

##### **Criterion 1**

Important strengths of Illinois' community-based mental health system as described under Criterion I include:

- ✓ The array of core services that are available to adults with serious mental illnesses.
- ✓ Commitment to a recovery orientation by mental health system stakeholders.
- ✓ The focus on consumer and family driven care to actualize key goals identified by the President's New Freedom Commission.
- ✓ Commitment to the implementation of evidence-based practices.
- ✓ Involvement of consumers in planning, implementing and evaluating the initiatives and ongoing activities of the public mental health system..
- ✓ Successful efforts to reduce hospitalization. Screening and crisis services that contribute to this success remain a high priority for DMH, as well as extensive case management services, community support and ACT.
- ✓ Collaborations with other divisions of the IDHS and with code agencies have been a successful strategy for improving and enhancing services throughout the system.

##### **Criterion 2**

Important strengths of Illinois' community-based mental health system as described under Criterion 2 include:

- ✓ Joint work with the newly established Illinois Mental Health Collaborative towards establishing and maintaining a data warehouse which will provide improved and expanded access to data which is vital to support decision making.
- ✓ The DMH has an extensive array of computerized information that provides an important resource for analyzing service provision and service needs.
- ✓ Through federally funded studies and DMH initiatives, our databases and analytic capabilities have steadily grown.
- ✓ External resources, such as the Data Infrastructure Grant have continued to assist MIS development and system analysis which remain an important DMH priority.

- ✓ Since FY 2006, all individuals seeking mental health services have been assigned unique ID numbers which are also being assigned to consumers who access services under other Divisions within DHS, as well as to individuals receiving services through the Child Welfare System and through the Illinois Corrections system. This will lead to improved tracking of services received by consumers across state systems, as well as increased accuracy through the unduplication of consumers receiving services in the mental health system.

#### **Criterion 4**

- ✓ Continued commitment to developing and implementing service models for persons with mental illnesses who are homeless.
- ✓ Active collaboration and effort to develop and evaluate approaches to improving housing services such as Permanent Supportive Housing (PSH) and successful advocacy for appropriations from the state legislature to support these promising approaches.
- ✓ Through the innovative use of PATH funds, Illinois has continually increased services including expanded intensive outreach to homeless individuals with serious mental illnesses.
- ✓ The CCSR serving Greater Illinois are committed to developing and implementing service models for persons with mental illnesses who reside in rural areas. As we have noted, the DMH participates in a range of collaborative initiatives such as the Governor's Rural Affairs Council, and works with nearby universities to develop and evaluate programs designed for the needs of rural residents. Direct services that include crisis/emergency services, outpatient services, psychiatric services, care management, PSR, and residential services are provided in rural areas across the state.
- ✓ Public Act 95-16 signed by the Governor in July, 2007 recognized the value of advanced technology in communication to give Illinoisans living in rural communities increased access to psychiatric care and requires the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via telepsychiatry. The DMH Geropsychiatry program, although it is small, has been nationally recognized. It is targeted toward the needs of older adults with mental illness, especially in rural areas.

#### **Crtierion 5**

- ✓ The DMH has made a substantial, successful and sustained commitment toward increasing the portion of the DMH funds allocated to community-based treatment for persons with mental illnesses.
- ✓ In recognition of the increasing role played by federal Medicaid funds, the DMH has worked successfully to increase this revenue source.

- ✓ The DMH has maintained a strong joint public and academic program which continues to include Departments of Psychiatry, Social Work, Psychology, and Nursing in universities across the State. All state hospitals in Illinois have agreements with universities to serve as training sites for psychiatric residency programs. Similar programs with Departments of Social Work, Psychology, and Nursing in universities across the state provide fertile ground for the recruitment of program graduates who are well grounded in public mental health as a result of their residencies.
- ✓ Innovative directions in the use of limited fiscal resources to promote expansion and growth of needed services such as initiating a fee-for-service payment mechanism to purchase services for individuals from community mental health agencies.

# Illinois

## Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

The FY 2009 Illinois Mental Health Block Grant Plan has been developed taking into account service needs and critical gaps within the current mental health system. The identification of these needs and tracking of the progress in meeting these needs using both quantitative and qualitative information is detailed in the Adult Plan and the Child Plan in Section III. The need to address issues such as the adoption and implementation of evidence-based practices, to address the needs of individuals (adults and youth) involved with the justice system, to provide access to services to adults and children residing in rural areas of the state are described in Section III. Please review the section as referenced.

# Illinois

## Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

## **Adults - DMH Priorities and Plans to Meet Service Needs**

### **Criterion 1**

The following are the priorities and plans for enhancing the adult service system in FY2009:

- Efforts to facilitate and improve the quality of consumer participation have been of paramount importance in Illinois and are the source of many strengths. The expansion of the scope of consumer and family involvement continues to be a priority.
- Consumer participation objectives for FY2009 support the DMH priority for furthering work on the recovery vision in Illinois.
- The institutionalization of the Certified Recovery Support Specialist (CRSS) credential continues to be of paramount importance. Expanding educational opportunities to meet the requirements and obtain the credential as well as creating employment opportunities in provider agencies are priority activities for FY2009.
- The expansion of WRAP programs continues to be an important focus. Family involvement in the development and implementation of treatment plans is important.
- Enhancement and expansion of evidence based practices is required to provide consumers increased access to proven quality services in family psychoeducation, medication management, ACT, supportive employment and permanent supportive housing.
- As housing is considered the #1 need of consumers transitioning into the community, of those who have found themselves homeless, and of consumers who are living in substandard environments, the viable development and establishment of the Permanent Supportive Housing initiative will be a primary area of interest and effort in FY2009.
- Collaborative initiatives which respond to ongoing consumer needs such as work with the criminal justice system, with providers of alcoholism and substance abuse services, with providers of vocational and employment services, and the Department on Aging on the mental health needs of older persons must continue as a priority.
- Maintaining and enhancing activities aimed at reducing hospitalization such as crisis services, face-to-face screening prior to hospital admission, case management services, including the ACT program community support , and the development of community-based resources for ongoing clinical care and supportive services in the community remain an important DMH priority.

### **Criterion 2**

The DMH places a high priority on the maintenance and improvement of its management information systems to meet the challenges ahead. This work has been valuably

supported by the requirements and activities undertaken through the Data Infrastructure Grant.

#### **Criterion 4**

The priority for DMH in working with the special populations described in this criterion, is to promote work on models of service provision which can best meet their needs. Integrated service models need to be adapted and utilized for the many homeless persons who have co-occurring mental illnesses and substance abuse problems. Increased homelessness in rural areas indicates the importance of expanding services for this population. Work with IDOA to expand the Geropsychiatry program more broadly in rural areas and to develop statewide applications continues to be a priority. IDOA has the support of the growing population of aging citizens in the state who want better health services, including mental health services. These individuals can be a rich source of support in expanding the availability of specialized services to meet the needs of this population.

A DMH survey some years ago found that major concerns across rural counties include the need for transportation and for “one-stop” services shopping. These concerns suggest the need for service partnerships among state agencies. Under the auspices of the IDHS, just such a partnership, Team Illinois, has been developed to improve the lives of persons residing in poverty-stricken, service deficient rural areas which are selected for the targeting of a broad range of state-operated and state-funded services. Bringing mental health services to persons isolated by distance and shortages of clinical professionals through approaches such as video-conferencing and telepsychiatry is a matter of urgent importance.

#### **Criterion 5**

- Increasing revenue from federal Medicaid funds to offset the fiscal problems Illinois has experienced in recent years which has led to decreases in allocations for human services.
- The development of alternative cost efficient training supports remains a priority. The DMH does not have dedicated resources for a training department of its own and fiscal problems have resulted in the cancellation of several training contracts in the past few years.
- Training events that assist in the implementation of the Recovery Vision in Illinois as well as training related to evidence-based practices continue to be a priority of DMH.
- DMH has recognized the urgency of a statewide mental health plan for responding to terrorist activities, as well as natural and other disasters.

# Illinois

## Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

## **Significant Achievements and Progress Toward Development of a Comprehensive Community Mental Health Based System of Care**

### **Consumer Participation and Involvement**

During FY-2008, the DMH continued work on several exciting initiatives aimed at enhancing recovery services. In-service training on the foundational principles of recovery and the implementation of a recovery-oriented system continued to be provided.

DMH has recognized the need for providing consumers with current, accurate and balanced information regarding changes in the service delivery system, empowering them to take an active, participatory role in all aspects of service delivery. In FY2008, Block Grant funds were expended to conduct pre-arranged conference calls with consumers in all parts of the State. Eight statewide calls were held for consumers with the number of participants ranging from 325–700. In FY2009, Block Grant funds will again be expended for this project. These calls provide a forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers' awareness, knowledge, and the tools they need to cogently and effectively participate in the development and evaluation of the service system.

In collaboration with the Illinois Certification Board (ICB), the Divisions of Mental Health, Rehabilitation, and Alcoholism and Substance Abuse have developed the Illinois Model for Certified Recovery Support Specialist (CRSS). The Model has defined baseline competencies and skills for CRSS professionals. Access to this new credential became available through the ICB beginning in July of 2007. As a means of disseminating information regarding this new credential, training on the conceptual approach to certification has been provided for interested stakeholders at conferences.

Under the leadership of the DMH Director of the Office of Recovery Support Services, the Wellness Recovery Action Plan (WRAP) model has been adopted by Illinois. A statewide WRAP steering committee meets on a monthly basis to plan and review progress on the WRAP initiative. Through the establishment of WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this emerging best practice in recovery-based services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois in FY2003, over 200 individuals (including consumers currently receiving services) received Certificates as WRAP Facilitators through their completion of a 40-hour intensive course. Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators.

DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual consumer conferences in each DMH region. These conferences typically have a well-known national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference. Consumer education is provided through a variety of venues in the state. Eight regional conferences were held across the state during

FY2008. Hundreds of consumers, family members, providers, DMH and other state agency staff attended these conferences.

C&A Services focused on family participation by increasing the availability of family resource developers (FRDs) and the advisory role of youth who utilize or have utilized services. Of the 43 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2008 FRD survey was conducted 84% of the SASS agencies had FRDs employed. Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the Federal Systems of Care demonstration grants also attend these meetings. Each System of Care site has emphasized the importance and hiring of FRDs. While the survey results could not specify the number of FRD positions that were FY 2008 new hires, it was noted that their support role has expanded as some agencies are using FRDs to assist with Individual Care Grant application processes and service planning. Other agencies have hired more than one FRD into their agency as they continue to recognize the value of the position.

The Teen Advisory Group consists of youth who are currently, or have previously, utilized C & A services. The group consists of six members who meet monthly. Meetings were held each month in FY2008 to provide feedback to the C & A network regarding quality of care and youth perception of service need. Members of the group are compensated for each meeting they attend. During FY2008, the group has been working on developing youth leadership skills following the graduation of several experienced committee members in FY2008. The youth have been developing a project involving the impact of the media on mental health, and assessing the way mental health issues are portrayed in various media outlets. This objective will continue in FY2009.

### **Evidence-Based Practices**

During the year, the DMH continued major initiatives to adopt and implement evidence-based practices in various areas across the state. Work continues to implement Supported Employment (SE), Family Psychoeducation, Integrated Dual Diagnosis Treatment (IDDT), Medication Algorithms and Wellness Recovery Action Planning. As an early adopter of Assertive Community Treatment (ACT), the DMH continues to work with agencies to ensure that the evidence-based ACT model is utilized within the State. Work also has continued on two SAMHSA System of Care grants. One involves all child-service systems and partnerships in the Metropolitan Chicago area. The second involves child service systems and partnership in McHenry County, Illinois. A major focus of these grants is the adoption of evidence-based and best practices.

The DMH has made significant strides in implementing and planning for the implementation of EBPs in the last few years. Efforts are underway to pilot each of the adult EBPs identified by SAMHSA. In July 2007, the DMH convened a statewide conference, entitled Evidence-Based Practices in Illinois: A State of Change. Experts on each of the EBPs made presentations on focusing on implementation, organizational and financing issues that should be taken into consideration when planning for implementation. Approximately 300 individuals (consumers, family members, advocate, providers and state agency staff) attended the two-day conference. These efforts address

SAMHSA'S National Outcome Measure of Implementing Evidence-Based Practices.

### **Systems Integration**

The DMH continued collaborations with many system partners including, collaboration with the Education system on the Positive Behavior Interventions and Support Model. The DMH continued its partnership with the Illinois Department of Healthcare and Family Services (the Illinois Medicaid agency) and the Illinois Department of Children and Family Services (the Illinois Child Welfare Agency) on the purchase of Screening, Assessment and Support Services (SASS) for children and adolescents and their families. DMH and the Division of Rehabilitation Services' continue its collaboration the 'Brand New Day Initiative' and the provision of Benefits Planning, Assistance and Outreach Project funded by the Social Security Administration. DMH also collaborates with the City of Chicago Mayor's Office for Persons with Disabilities on the latter initiative.

### **Program Enhancement**

The DMH continued work on a SAMHSA funded statewide initiative to move toward a violence-and-coercion-free hospital environment, reducing the need for seclusion and restraint as alternative person-centered interventions are established.

### **Fee For Service**

The DMH has revised Medicaid Rule 132 to support the service system changes that will be necessary in the transition to a Fee-for-Service System. Planning efforts and gradual implementation of this initiative in key program areas has continued in FY2008. DMH also continues to work with consultants to identify technical assistance needs of providers and to provide technical assistance to support the move to the fee-for-service system.

### **Information Technology**

DMH continues its efforts to refine and streamline data collection efforts to provide information that supports decision-making. As noted above, DMH, working with the Mental Health Collaborative for Access and Choice (MHCAC), has redesigned and is implementing a new management information system (MIS). This work includes the development of a data warehouse that will house eligibility, registration, billing/services information, a provider database, and service authorization in one place. DMH will have unprecedented access to this data. One of the updates to the MIS is the requirement to update key clinical and demographic fields that will be used to track consumer outcomes over time.

### **Grants**

In FY 2008, the DMH received continuation grants for the following areas: Data Infrastructure for Quality Improvement; Work Incentive and Planning Assistance Services for SSI/SSDI Beneficiaries, Supported Employment; a SAMHSA Targeted Capacity Expansion - Jail Diversion grant called the *Community Reintegration Collaborative* to support the DMH Jail Data Linkage Program; and two grants in child and adolescent services: System of Care-Chicago which ends this year, and a second System of Care grant focusing on McHenry County originally awarded by SAMHSA in 2006. In FY2008, DMH partnered with staff of the Illinois Department of Healthcare and Family Services (DHFS) in applying for and obtaining a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provides \$2 million over a two-year

period to improve access to, and quality of, primary health care services. DMH was also awarded a SAMHSA Transformation Transfer Initiative grant for \$105,000 to fund a statewide mental health/criminal justice needs assessment and system mapping initiative.

The System of Care-Chicago (SSOC) project was developed in response to the multiple needs of children and youth who are involved in several service systems. Planning for the service implementation began in the first year of this five-year, \$9.5 million grant from SAMHSA. A curriculum on evidence-based practices was developed based upon information regarding the types of mental health challenges and diagnoses presented by the children involved in the initiative. Significant goals for training in evidence-based practices were established last year and a major training effort has been implemented.

In FY 2006, a new award was made by SAMHSA to expand System of Care principles and practices to McHenry County, thus providing the opportunity to expand the System of Care model to other areas in Illinois and the project has shown rapid development. Family CARE stands for Child/Adolescent Recovery Experience and is a \$9 million, six-year federal grant designed to involve families and youth in decision making related to treatment, goal-setting, designing and implementing programs, monitoring outcomes and determining the effectiveness of efforts that promote the well-being of children and youth. The grant is designed to improve access to services for five underserved populations who present with mental health and substance abuse issues: preschoolers with serious social/emotional problems, youth with mental disorders, youth with co-occurring mental health and substance abuse issues, young adults 18-21 years old, and Latino children. For more information on these grants, see Section II, Criterion 3 of the Child & Adolescent Services Plan.

In summary, each of these initiatives is contributing to mental health system transformation efforts and toward the continued development of a comprehensive community based mental health system of care.

# Illinois

## Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Illinois continues to make substantive progress in developing a transformed, comprehensive mental health system for adults with serious mental illnesses and youth with serious emotional disturbances and their families. Illinois envisions a well resourced transformed mental health system that is consumer directed and community driven, providing a continuum of culturally inclusive programs which are integrated and effective; the provision of a range of direct and support services that support healthy lifelong development through equal access and that promotes recovery and resilience for the citizens of Illinois. The Illinois vision for mental health is "The Expectation of Resilience and Recovery through Treatment, Accountability and Equal Access". A review of the Illinois plan shows that Illinois has made great strides during the past year toward achieving this vision.

# Illinois

## Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

# **CHILD & ADOLESCENT SERVICES PLAN**

## **SECTION III: DESCRIPTION OF SERVICES**

---

### **Criterion I: The Comprehensive Community Based Mental Health System**

#### **Organizational Structure of the Illinois System of Care**

##### **Overview**

Illinois has made substantive progress in developing a comprehensive mental health service system for youth with serious emotional disturbances (SED) and their families. Illinois envisions a well resourced and transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs and services including prevention, early intervention and treatment, that promote healthy lifelong development through equal access and support recovery and resilience. In Child and Adolescent services, the emphasis is on resilience and evidence informed practice as components in the systemic transformation process. Many of the activities in which the DMH is engaged are providing the foundation to make this vision a reality.

#### **Organization of the Comprehensive System.**

##### **Central Office Structure**

The Child and Adolescent Services office is led by a board certified Child and Adolescent Psychiatrist and consists of 28 FTE Statewide C&A Staff who are geographically located in each of five regions of the state. Contracting responsibilities have shifted to the Regional staff who are often accompanied by and/or receive consultation from C&A staff. The model appears to be working well, reducing duplicated effort and allowing the Regions to draw upon C&A staff expertise to support their contract and monitoring role.

##### **The CCSRs**

The five geographic Comprehensive Community Service Regions (CCSRs) are responsible for contracting activities with 151 community-based outpatient/rehabilitation agencies which include 124 child serving agencies which are either specialized or are community mental health centers with children's programming. They also contract with local hospitals that provide psychiatric programs for youth. The localized integration of a comprehensive care system including mental health, substance abuse, child welfare, juvenile justice, and education is within their purview. Each CCSR has assigned staff specially designated to address child and adolescent and juvenile forensic services.

##### **The Illinois Department of Human Services**

Being part of IDHS has provided an opportunity for the DMH to address a number of challenges within the shared mission of one Department such as: prevention, early intervention, integration of vocational and educational services, coordination and

development of Mental Illness and Substance Abuse (MISA) services and, through the coordinated intake process, an opportunity to enhance case finding, early identification, and outreach efforts.

## **Available Services and Resources in the Comprehensive System of Care**

### **Health, Mental Health and Rehabilitation.**

#### ***Health***

***"There is no Health without Mental Health"*** has been the slogan of the Division of Mental Health for the past seven years. The DMH continues to emphasize the importance of assisting families of children and adolescents with serious emotional disturbances in accessing Medicaid and state insurance benefits.

**Illinois Health Care Programs:** The State of Illinois has a key initiative to ensure access to health care for children and adolescents- All Kids which is administered by the Illinois Department of Health Care and Family Services (DHFS). Funded by the Legislature in FY2006, All Kids is the Governor's state program that offers comprehensive, affordable health insurance for children in Illinois. All Kids was the first program in the nation to make sure that every uninsured child, regardless of income or medical condition has access to health care. All Kids began July 1, 2006 when the previous insurance program, KidCare, was folded into All Kids. Children who had not been eligible under the Kid Care program became eligible for benefits under the All Kids expansion. The program provides access to healthcare services for all children 18 years or younger who live in Illinois. Every uninsured child may be eligible regardless of income, current health condition or citizenship. Children must have had no insurance coverage for a 12 month period to qualify for All Kids except a newborn child, a parent who lost a job which provided insurance benefits, and a child on COBRA insurance. Children with insurance coverage may also qualify if their families meet certain preset income limits. All Kids provides access to the following services: doctor visits, hospital visits, dental care, vision care including eyeglasses, prescription drugs, check-ups, immunization shots, and it covers special medical services such as medical equipment, speech therapy and physical therapy and mental health services. The amount a family pays is based on their income: Some families will have no monthly costs. Families who have more income will pay reasonable monthly premiums and co-payments. There are never any co-payments for regular check-ups or immunizations

In addition to the All Kids program, Family Care extends healthcare coverage to parents living with their children 18 years old or younger. Family Care also covers relatives who are caring for their children in place of their parents. Like All Kids, Family Care covers doctor visits, dental care, specialty medical services, hospital care and emergency services. Parents can get Family Care if they live in Illinois and meet income limits which go up as the family size goes up. For example, a family of four can make up to \$36,000 per year and may be eligible for Family Care. Parents must be US citizens or meet immigration requirements. Applications for coverage by these programs are easy to

obtain through a toll-free telephone number (1-866-ALL-KIDS) or on-line at [www.allkidscovered.com](http://www.allkidscovered.com).

Through All Kids, Illinois has created a continuum of health benefits coverage for low-income children in the state. The plans are funded by state revenue, as well as federal funds under Title XIX, Medicaid, and Title XXI, the State Children's Health Insurance Program. All Kids Assist covers children from birth through age 18 whose family income is at or below 133 percent of poverty. All Kids Moms and Babies covers pregnant women and their babies with family income at or below 200 percent of poverty. Individuals enrolled in these plans have no cost sharing requirements. All Kids Share covers uninsured children with family income above 133 percent and at or below 150 percent of poverty. Families pay a small co-payment for some services. All Kids Premium covers uninsured children with family income above 150 percent and at or below 185 percent of poverty. The families of these children pay modest monthly premiums in addition to co-payments for some services. Children who have health insurance whose family income is above 133 percent and at or below 185 percent of poverty are eligible for All Kids Rebate. Under this program, the state reimburses families for all or part of the cost of purchasing private or employer-sponsored health insurance for their children. All Kids Assist and All Kids Moms and Babies cover a full range of Medicaid services including dental care. All Kids Share and All Kids Premium cover the same services with the exception of abortions and home and community-based waiver services. All four plans cover a broad range of benefits for special needs populations. The same provider networks (including physicians, pharmacies, and community mental health and substance abuse providers) are used for all four plans.

### ***Mental Health Services***

The array of core mental health services purchased on behalf of Illinois citizens with mental illnesses are based on the tenets of the Community Support Program (CSP) and Child and Adolescent Support Services (CASSP) models. They are described in the Provider Handbook which has been issued by the Mental Health Collaborative, the private organization which is assisting DMH with the organization and evaluation of service delivery. The following is a brief synopsis of core services provided to children and adolescents.

**Acute Care.** Acute Care Program services provide a rapid response to children and youth in a mental health crisis, to members of the support system, and the community on a 24-hour a day basis. These services are intensive, short-term, and are oriented toward stabilization of an individual's condition and management of disruptive and life threatening symptoms. Services include crisis-emergency services (e.g. mobile, walk-in and telephone response, crisis residential services and hospital-based services).

**Mental Health Treatment.** These services, which are intended to reduce psychiatric symptoms and promote adaptive functioning, are based on an evaluation of an individual's mental health service needs and an individual treatment plan (ITP) that is monitored, reviewed, and modified as needed on an ongoing basis. In addition to the core services offered in outpatient settings (e.g., Assessment, Treatment Planning and

Monitoring; Counseling and Therapy Services; Psychiatric Services: Medication-related Services), youth with serious emotional disturbances and their families may receive specialized core services including **Screening**, Assessment and Support Services (SASS); Child and Adolescent Wraparound Services; and services through the Individual Care Grant Program for Mentally Ill Children (ICG/MI).

Screening, Assessment and Support Services (SASS) programs were first established in 1989. The primary objectives of SASS are to develop community-based screening and assessment capability, intensive home-based services, and crisis intervention services. The philosophy of service is short-term intervention which is child-centered, family-focused and community-based. Parents are involved in service provision and evaluation. Since FY2005, the DMH has participated in a significant effort to deliver SASS services collaboratively with the Department of Children & Family Services (DCFS) and the Department of Healthcare & Family Services (DHFS).

Wraparound Services. The Wraparound Approach is essential to the provision of case management services. DMH has defined the way these services are to be provided to families, offering both traditional and non-traditional supports by using the local network of community providers and associations. In this approach, there is a definable planning process involving the child and family, which results in an individualized plan for that child and family that focuses on strengths and needs across multiple settings.

Individual Care Grant For Children with Mental Illness. The DMH Individual Care Grant (ICG) Program provides funds for residential treatment or intensive community treatment for children and adolescents with serious emotional disturbances who meet the criteria of severe mental illness and impaired reality testing. If the funding is awarded for a community grant, parents and providers work together to provide highly individualized services in the community. These individualized services include intensive home-based support, treatment and respite care which allow the child to remain at home. A parent, along with the community mental health center may also decide that residential treatment is the appropriate option. Families are encouraged to place their children close to home to optimize parental involvement in treatment. In FY2007 81 new ICG grants were awarded. As of June 30, 2007, there were 484 active ICG cases. One hundred fifty-three children and adolescents received community services under the ICG program which represents 32% of ICG families. An ICG Advisory Council was established in FY2001 and continues to provide input to planning and service delivery.

### ***Rehabilitation***

As noted in the adult service section rehabilitative support services are funded by DMH. For children, the service focus is on Case Management which consists of supportive services including Case Management, Client Transitional Subsidies, and Transition to Adult Services.

### **Employment Services**

Employment is considered one of the key services required for youth transitioning to adulthood. The DHS Division of Rehabilitation Services (DHS/DRS) helps high school students with disabilities plan for their future and assists these students in finding employment with services provided through the Transition Program and the Secondary Transition Experience Program (STEP). DHS/DRS have a strong commitment to

serving school age youth with disabilities. The counselors work closely with transition specialists housed in high schools, staff in individual schools and school districts, and community partners to help students achieve their employment, post-secondary education and independent living goals. Whether in school or out, a young person with any limiting disability may be eligible for assistance. DMH and the DHS Division of Rehabilitation Services (DRS) have collaborated closely in a joint effort - "The Brand New Day Initiative" - to increase access to vocational rehabilitation services including supportive and subsidized employment and to improve the coordination of psychiatric and vocational services. Locally, services for youth and adults are obtained through joint planning and service efforts by community mental health centers (CMHCs) and local offices of DRS.

Other DRS Transition Initiatives that serve students with disabilities and benefit youth with SED include:

- STEP Program ~ The Secondary Transition Experience Program (**STEP**) is a work training/placement program to prepare youth for transition to employment during and after high school. The purpose of STEP is to offer students with disabilities, as part of their Individual Education Plan (IEP) and Transition Plan, the opportunity to participate in career exploration, independent living experiences and community work experiences in preparation for a life after high school, and particularly employment. DRS has 150 STEP contracts which serve approximately 600 high schools.
- DRS maintains Cooperative Agreements with Illinois State Board of Education and local school districts. DRS Transition Specialists participate in ongoing education/vocational rehabilitation planning and in the development of the vocational/transition portion of the IEP. The cost of these specialized counselors is shared between the local school district and DHS/DRS. Services for students who have not achieved their vocational objectives by the time they leave school are continued through the local DRS office. Each DHS/DRS office assigns Vocational Rehabilitation counselors to schools to assist students' transition from school to work.
- NEXT STEPS, a training and resource system, uses volunteer teams to provide training to parents and caregivers in planning and advocacy for positive transition outcomes for children and youth with disabilities. The NEXT Steps service network of 22 teams statewide is sponsored by DRS. Teamwork and workshops focus on four critical goals of Transition: Employment and Education, Independent Living, Social and Interpersonal relationships, and Self-Advocacy. Continuous outreach to un-served or underserved populations is practiced.
- Transition Planning Committees: DRS coordinates and sustains local Transition Planning Committees (TPCs) which identify existing resources and unmet needs, facilitate an on-going exchange of information, and develop local customer training programs.

## **Housing Services**

Housing services are generally not provided to children and adolescents, but they do benefit from housing services and programs if they are in a homeless family that requires shelter or if they are living with adult consumers who are being set up with permanent supportive housing. Child-serving agencies are cognizant of the critical needs of families and may refer or link them to appropriate housing services when the need is apparent. Residential Treatment services are provided through the ICG/MI program to children and adolescents who are unable to function in their home and community environments due to the seriousness of their level of emotional disorder. Children in the child welfare system may be placed in foster care and receive SASS services or they may be placed in group home or residential treatment programs by DCFS.

The DMH continues to implement the Urban Systems of Care (USC) initiative which established community-related services tailored to the needs of children and adolescents who are at risk of emotional problems or who are exhibiting such problems and need to be linked to a local mental health provider. The approach requires collaboration with key community stakeholders and relies upon a wraparound approach to service delivery as an effective intervention. The aim of this program is to sustain families in their environments, prevent homelessness, and support them in obtaining appropriate housing alternatives as needed.

## **Education Services**

### Special Education In Illinois

The Illinois State Board of Education (ISBE) reports that 15% of Illinois students of school age (ages 6-21) received special education services in the 2005-2006 school year. Ten percent (10%) of those receiving special education services were classified as Emotionally Disturbed (ED) (28,789 students), the special education category that most closely approximates the federal definition of Serious Emotional Disturbance. Another 8,143 students were classified under Autism.

For pre-school children ages 3-5 years, the number receiving special education services is increasing annually (6.44% in 2004, 4.66% in 2005, and 2.12% in 2006). More infants and toddlers with disabilities are being identified and served at a younger age. These children transition to early childhood special education services when they reach the age of 3. Collaboration with Head Start, pre-kindergarten, and child care programs has resulted in identification of more pre-school aged children who may need special education services and has provided more placement options for children with IEPs. There has been a gradual increase in the number identified with Autism going from 2.9% in 2003 to 3.67% in 2006, (1,312 of the 35,708 children in that age group who received special education services in 2006), reflecting greater accuracy in the early childhood diagnosis of this disorder. ISBE identified 236 children in this age group as being in the ED category bringing the total number of children ages 3-21 classified with an emotional disability in 2006 to 29,025.

### Transitional Education

A new law establishes uniformity in the School Code making students statewide eligible to receive special education services up until the day of their 22nd birthday. It helps assure that students with disabilities are able to continue to receive the educational services they need to become productive adults. For young adults in the Individual Care Grant (ICG) Program, educational and vocational services must be an integral part of the transition plan as they move to adulthood. Since the ICG youth are identified as having serious emotional disturbances, early vocational training is highlighted and some begin this as part of their residential treatment. The Adult Network and ICG Transition Coordinator also work with the Division of Rehabilitation Services (DRS) and with the Illinois State Board of Education (ISBE) to develop, coordinate and finalize transition plans for these young adults. (See also the mental health in schools model described later in this section.)

### **School Systems: Service provision under the Individuals with Disabilities Education Act (IDEA)**

When DMH partnered with ISBE and DCFS to implement the wraparound approach to the delivery of children's services, it was clear that children served under the Individuals with Disabilities in Education Act (IDEA) were most often those who required community based mental health care. The Wraparound approach strengthened the collaboration needed to serve these youth and made the shared agenda of community mental health providers and schools of greater importance. The DMH has pursued a model of service provision that meets the needs of local schools while also addressing the needs of children served through the Individuals with Disabilities in Education Act (IDEA). The model is organized around the needs of the families, schools and communities. This approach includes universal, selected and targeted strategies while addressing cultural factors, stigma, outreach and other barriers to engagement. As a result students experience school wide behavioral interventions, which promote learning and provide positive approaches to the task of learning as well as integrated mental health services.

### **Substance Abuse Services for Youth**

Services for youth with substance use problems are provided through the IDHS Division of Alcoholism and Substance Abuse (DASA), which administers funding to a network of community-based substance abuse treatment programs. DASA programs provide a full continuum of treatment including outpatient and residential programs for persons addicted to alcohol and other drugs.

### **Services For Youth with Co-Occurring (Substance Abuse/Mental Health) Disorders**

The DMH C & A Directors, in collaboration with the DASA, continues to explore the need for staff training and current program capacity issues to address the clinical needs of this population in the Chicago area.

## **Medical and Dental Services**

Both of these essential healthcare services are available to children and youth with SED regardless of income and are accessed through case management or referral. Mental Health providers actively assist families to obtain health insurance coverage for their children under the All Kids program and to be assisted with medical bills through Medicaid. SASS agencies in particular, require families to apply for Medicaid benefits as part of their admission process. In some areas subsidized clinics are available to provide these services at minimal cost and access can be facilitated by the mental health provider.

## **Support Services**

### IDHS

An extensive range of services are available to youth with serious emotional disturbances through IDHS. Liaisons have been developed between local community mental health centers and local IDHS offices for the purpose of facilitating consumer entitlements and identifying those IDHS clients who are in need of assistance in accessing mental health services.

### Family Assistance Program

The IDHS administers the Family Assistance Program which is legislatively mandated in Illinois. The Family Assistance Program provides a monthly stipend to enrolled families who have a child with a serious emotional disturbance (SED) or developmental disability (DD), which they can use for treatment and/or specialized care services at their own discretion. Parent enrollees must have an annual income of \$50,000 or less. Selection for the program is by application and random selection. The program currently serves 46 families of SED children.

### MHJJ- Juvenile Justice System.

Experts in mental health and juvenile justice estimate that the rate of mental disorder among youth in the juvenile justice system is substantially higher than among the general population of youth. It has been estimated that 14% of youth in juvenile detention have a major depressive disorder and may also have a co-occurring substance abuse disorder. These youth have disorders that can be effectively treated with psychopharmacological and behavioral interventions, which are usually more successful when they are coordinated with other major service systems impacting the child and family. DMH has funded the Mental Health Juvenile Justice Initiative since FY2000 to address this need. This successful initiative is now statewide and provides services to juveniles detained in all the detention centers in Illinois.

### Post-Traumatic Services

For the past three years the Illinois Department of Children & Family Services (DCFS) has funded a training initiative for child welfare staff and service providers to examine and respond to the trauma children and families have experienced as a result of physical abuse, neglect, sexual abuse and domestic violence and its effect on their behavior, performance and adjustment, especially in foster care and other supportive environments. The DMH statewide Child and Adolescent Services office has consultatively participated in the development of the initiative. In FY2008, funding was provided through the

Illinois Children's Mental Health Partnership to expand this education and training initiative to mental health providers. DMH C&A staff work closely with DCFS to adapt the components of the DCFS approach to a broader population and develop an effective training model to support mental health trauma work with children. The Train-the Trainer phase has been completed and certified trainers are delivering training to DCFS and DMH funded provider staff in FY2009.

### **Case Management for Children and Adolescents**

Youth with serious emotional disturbances and their families, by the nature of their difficulties, cannot be served in isolation. Case Management, a required service for youth with serious emotional disturbances who receive substantial services through the public mental health system, is defined as the coordination of services between the mental health provider and other agencies in order to provide the child and family with immediate and comprehensive care. It is considered a critical component in the effort to assure continuity of care, to sustain youth with serious emotional disturbance in his/her community, enhance his/her quality of life, and thereby reduce the use of state hospitals. Community mental health agencies serving children have been required to participate in local networks of child-serving agencies, which facilitate supportive services to families. In an outpatient setting, case management is an outreach-oriented set of service activities at variable levels of intensity, determined by client need, with the intention of maintaining the client's linkage to necessary mental health services and social supports within the least restrictive clinically appropriate setting. Intensive case management is provided to especially high risk groupings of children who have multiple, severe needs requiring extensive in-home supports and involvement among various child-serving systems.

The Screening Assessment Support Services (SASS) initiative was designed to support an integrated network of individualized services that would meet the specific needs of youth and their families. SASS programs offer case management services to facilitate access to the health, welfare, educational, medical, dental, and vocational services required by these youth and their families. In crisis situations or in cases following hospitalization, A SASS case manager assumes primary responsibility for identifying and accessing needed services for the child and family through mobilizing the family's natural helping network and utilizing community resources. All SASS providers are required to sign Continuity of Care Agreements with state hospitals and state-funded hospital programs for youth and are monitored for compliance by CCSR through performance measurements.

### **Youth Transitions:**

The DMH recognizes the importance of developmental passage for young adults with serious emotional disturbance and strongly encourages active clinical support to youth who are in need of continuing into adult services. These youth are typically without the education and vocational skills that could facilitate their employment and may also lack the family support that many young adults now enjoy until their mid-twenties. Those who

have lived in institutional settings for a long time do not have the community living skills or the community connections that aid in the transition to adult life. Without support, these youth are at risk for joblessness, homelessness, incarceration and welfare dependence. Adult Networks and community-based providers work with the young adult to assure needed services and supports are in place.

In FY2007, initial grants of \$100,000 each were awarded to one agency in each region to conduct a pilot project in transitioning youth. The projects addressed two transitional groups: (1) Youth who have received services in the Child & Adolescent System who are 16 and older and need to prepared to enter adulthood and be served by the Adult system. (2) Youth with serious emotional disturbances transitioning from correctional services back into their home communities are targeted for services regardless of their age. To facilitate the transition process for those re-entering from correctional services, two full time statewide C&A staff were assigned the task of acting as liaisons with the eight state correctional centers which house youth. The focus of these pilots was on infrastructure building and basic services. These programs are providing information on the kinds of models which work best. In FY2008, an additional five pilot projects were initiated at \$100,000 each bringing the total state allocation to \$1,000,000.

Child Welfare wards who reach the age of 18-21 and are in need of specialized services due to serious emotional disturbances are the subjects of collaborative work between DMH and the Department of Children & Family Services (DCFS). DCFS has funded two Transitional Living Programs (TLPs) for wards with serious emotional disturbance and DMH has funded the required mental health services. Although capacity is available for 50 residents, the programs are serving 25 residents at any given time as a means of providing more intensive programming. The Thresholds program in Chicago has fifteen residents and the SIRSS program in Carbondale serves ten. An oversight committee composed of staff and providers from both departments meets monthly to review and develop a common agenda and work out problematic situations. DCFS funded providers and mental health providers have been successful in resolving conflicts stemming from programmatic attitudes and policies.

### **Activities Leading to a Reduction in Child and Adolescent Hospitalization**

A variety of strategies have resulted in a significant reduction in admissions to state hospitals from 1,272 children and adolescents in FY1989 to 76 in FY2008. Currently, there are only two state operated inpatient programs for children and adolescents. One is a small 9-bed inpatient program at Choate Mental Health Center near the southern tip of Illinois. It serves 6-9 children with serious disturbances at any given time due to the absence of other inpatient resources in that area. McFarland MHC located at Springfield, has a 25 bed forensic unit for adolescent boys which generally serves only 15 boys at a time given the requirement for more intensive team intervention with this higher risk cohort. (Forensic services are also provided for DMH by contract with Streamwood Hospital.)

The Screening, Assessment, and Support Services (SASS) program has had a major impact on hospital admissions. SASS was initiated by the DMH in 1989 with a primary responsibility of screening adolescents prior to their admission to state hospitals. As

DMH began to fund community hospitalization, SASS expanded its screening efforts for these services providers as well. The SASS program was expanded to a tri-agency funded program (DMH, DCFS and DHFS) in FY 2005. Wraparound funding, as described above, is also utilized in efforts to keep children twelve years of age and under out of state hospitals in several areas of Illinois. This initiative utilizes SASS and other specialized community-based services to maintain the child in the community.

## **Criterion 2: Mental Health System Data Epidemiology**

### **INDIVIDUALS RECEIVING PUBLICLY FUNDED SERVICES**

#### **Prevalence Estimate**

For an estimate of Children and Adolescents with Serious Emotional Disturbance, Illinois has used the 7% estimate provided in the CMHS notice in the Federal Register, Volume 63, Number 137, July 17, 1998 based on the average of the lower limit at a level of functioning of 50 (LOF=50) and the upper limit at a level of functioning (LOF=60). The figure has been updated by CMHS using 2007 census information to 112,868 or a 6% estimate for children and adolescents aged 9 to 17 based on a 14% (FY2006) poverty rate.

#### **Definitions of DMH Population Eligible to Receive Services**

Descriptive eligibility criteria for core services provided in the Illinois public mental health system have been developed and specified using certain broad clinical-diagnostic categories as well as more specific indicators of need. Two groups of consumers are the focus for service provision: a larger “eligible” group and a smaller “target” group. Persons who fall in the eligible group meet a minimum criteria of mental illness or emotional disorder as well as significant impairment in life functioning and may be served in the Illinois mental health system. Persons who are considered part of the “target” population meet a much stricter and more debilitating level of mental illness and impairment and must be served. The CMHS prevalence estimation methodology seems to overlap the target and eligible population definitions that are currently used by the DMH. While there is a substantive gap between the total prevalence and the annual numbers served, we know that a certain percentage of these individuals may not need or request service in a particular year and an unknown proportion of those who do need service may be served in the private sector. Estimating the size of the unserved portion of the total estimated prevalence is contingent upon the availability of utilization data for privately provided psychiatric services which is not currently available.

#### **Definitions of DMH Eligible and Target Populations**

##### **The Eligible Population (Adults and Children/Adolescents):**

- Must have a mental illness, defined as “a mental or emotional disorder verified by diagnosis contained in the DSM-IV or ICD9-CM which substantially impairs the person’s cognitive, emotional and/or behavioral functioning, excluding the following

unless they co-occur with a diagnosed mental illness: V-codes, organic disorders, psychoactive substance induced organic mental disorders, mental retardation, pervasive developmental disorders associated with mental retardation, and psychoactive substance use disorders.

- Must have significant impairment in an important area of life functioning as a result of the mental disorder identified above and as indicated on the Global Level of Functioning (GAF) for adults and Children's Global Assessment Scale (CGAS) for children.
- All ages

**Definition of Child and Adolescent Target Population:**

- Must be 0 years of age through 17 years of age.
- Must have a serious emotional disturbance as defined by the diagnostic, functional, and utilization criteria.

**Demographic Factors**

See the Adult Plan, Section II, this criterion for a discussion of this topic.

**Children and Adolescents Receiving Services in FY2008**

The number of youth with Serious Emotional Disturbance (eligible population) reported served in FY2007 was 33,158 approximately 88% of the total served. Information on the number of persons served in FY2008 is derived from Basic Tables 2A and 2B, which is being prepared for the FY2008 Uniform Reporting System Tables.

**Progress In Performance Measurement For Adults With SMI And Children And Adolescents With SED**

*For a full discussion of this topic which is applicable to both adults and children, see this criterion in Section II of the Adult Plan.*

Child and Adolescent Outcomes Analysis: In FY2007, the DMH contracted with a web-based research company to develop a Web-based Clinical Outcomes Analysis system. The software consists of: (1) The OHIO Scale, a clinical instrument used at points in time, which yields evidence of positive or negative change; (2) The Columbia Impairment Scales for Parents and Youth; and (3) Goal Attainment Scaling methodology. Users of the web-based system are able to generate immediate feedback reports at each level of service. Clinicians are able to generate reports and graphic profiles on their individual clients across specified time periods. Agency site coordinators of the system will be able to generate agency wide service reports. DMH will be able to compile system-wide data from all the participating agencies. Providers have been trained during FY2008 and the system is operational.

### **Criterion 3: Children's Services**

**The grant under section 1911 for the fiscal year involved will not be expended to provide any service of such system other than comprehensive community mental health services:** The Block Grant funds of this grant will be expended to provide only comprehensive community mental health services. Other funding sources have been and will be available to fund the interagency collaborative efforts described below.

**Establishment of a defined geographic area for the provision of the services of such system:** Defined geographic areas (CCSRs) have been established for the provision of services.

**Responsible Agency for the Coordination of all Children's Services:**

Children's Services in Illinois are provided by several agencies under the direction of the Office of the Governor. The most prominent are: the IDHS, the Department of Children and Family Services (DCFS), the newly established Department of Juvenile Justice (DJJJ); and the Department of Healthcare and Family Services (DHFS). The Illinois State Board of Education (ISBE) oversees and provides guidance for educational services including health and social services funded by and provided in local school systems.

**Responsible Agency For the Coordination of State Children's Health Insurance Program (SCHIP):**

The Department of Health and Family Services (DHFS) is responsible for coordinating this effort which is known as All Kids (See Criterion I).

**Responsible Agency For Mental Health Services For Children:**

The coordination and development of a community-based system of public mental health services for children and families is the responsibility of the DMH.

**Description of Interagency Collaboration Initiatives**

**Background.** Beginning with the award of the Child and Adolescent Support Services Program (CASSP) grant in 1985, the IDHS has actively pursued interagency collaboration with other departments invested in providing services to children and families. The Joint Services Children Initiative funded by the DCFS and the DMH from 1986 to 1988 designed and delivered services to adolescents at risk of restrictive care either through involvement in child welfare or mental health. Subsequently, the Directors of the DMH and the DCFS finalized congruent geographic boundaries that facilitate access to service (1992). In 1994, the DMH, in collaboration with the Illinois State Board of Education, DCFS, and DASA, assisted in the development of Child and Adolescents Local Area Networks (C&A-LANs) and in the provision of Wraparound training throughout Illinois to increase coordination of care for youth with emotional or behavioral challenges. The Wraparound approach strengthened the collaboration needed to serve these youth and made the shared agenda of community mental health providers and schools of greater importance. The DMH has also pursued a model of service provision that meets the needs of local schools while also addressing the needs of children served through the Individuals with Disabilities in Education Act (IDEA).

## **Social Services.**

As described previously, the DMH collaborates with other Divisions under the umbrella of IDHS, as well as free-standing state agencies. Many of the social services that are needed by children and adolescents and their families are accessed through IDHS Divisions such as Human Capital Division and Community Health and Prevention. These services are described in more detail in Section I under specified headings.

### ***Systems of Care***

The Division of Mental Health is currently operating two System of Care grants funded by the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration/Center for Mental Health Services. The first System of Care grant was awarded to Chicago, funded in 2004, and is ending in FY2009. The second System of Care grant which awarded to McHenry County and was funded in 2006.

**The System of Care Chicago Grant:** The goal of System of Care Chicago (SOCC) was to implement a system of care based on the primary partnership established between DHS/DMH Child and Adolescent Services and the Chicago Public Schools. This effort was aimed at bringing together parents, youth, community networks and resources, along with the responsible child-serving agencies, which include local mental health centers, schools, healthcare providers, child welfare, substance abuse and juvenile justice, in order to meet the needs of children with serious emotional disorders and their families. Family involvement and cultural competence are the key issues that have been addressed throughout the initiative. Evaluation tools were designed to include child and family outcome data as well as findings related to the processes of system change itself. Service redesign was intended to blend evidence-based practices and non-traditional approaches and resources to address the full array of children's needs while identifying and enhancing the strengths of those families. Social marketing plays a key role in the dissemination of information regarding system of care development through quarterly newsletters, staff training, special events, and the development of communication pathways that decrease confusion and enhance collaboration.

To date, 380 families have received services from the SOCC since its inception and 284 families have been enrolled since obtaining IRB approval of the evaluation process in November 2004. One hundred eighty-six of the families enrolled in services since November 2004 were closed as of June 30, 2008. One hundred eighty-seven families (117 boys 70 girls) have been successfully enrolled in the national evaluation as of June 30, 2008. The data of the preliminary evaluation findings indicate that when wraparound interventions are implemented, children experience fewer clinical symptoms related to serious emotional disturbances. Improvements in family and school relationships have also been demonstrated. Reduced rates of behavioral sanctions (i.e., suspensions and expulsions), and increases in school attendance and academic achievement have also been positively associated with enrollment into the project. Patterns of service utilization also support that families experience improved access to services and supports.

The lessons learned through the experience of the implementation of the grant include:

- The need to continue to provide ongoing trainings and develop partnerships with child care providers over an extended period of time in order to address the barriers in getting some of the school staff and mental health professionals to understand the importance of family involvement and the role of the Family Resource Developer (FRD).
  - In light of an on-going struggle with the high turnover of the school-based mental health staff it was learned that the maintenance of school-based mental health staff is critical in order to successfully meet children's needs and attain enrollment goals. Processes and policies need to be implemented to assure the successful transition of staff into and out of school-based positions.
  - Cultural and linguistic competence is an extremely important value of system of care principles and requires a great amount of effort in helping community partners to embrace the values of cultural inclusion and respect. In view of this responsibility, the cultural competence coordinator position should be at least a half-time paid position. This will allow the time and attention to do an effective job.
- 

**The System of Care McHenry County** DMH, in collaboration with service providers, youth and families in McHenry County, are developing the Child/Adolescent Recovery Experience (CARE) system of care for the county's youth with serious emotional disturbances. The **overarching goal of this project is** to transform McHenry County's system of care for serious emotionally disturbed youth and their families through system-wide strategic collaboration and implementation. DHS/DMH has partnered with the McHenry County Mental Health Board to implement system of care transformation, on a local level. The mission of this project "*is to meet the social and/or emotional needs of families, children, and youth by providing leadership to develop and sustain a community of care that provides continuous support and easy access at every level of care.*" The grant will improve access to services for four underserved populations: preschoolers with serious social/emotional problems, youth with serious emotional disturbances and co-occurring substance abuse problems, young adults 18-21 years old with mental illnesses, and Latino children.

McHenry County Family CARE emphasizes the use of the System of Care values and principles to empower youth and families as well as to implement system-wide collaboration. The use of Child and Family Teams engages traditional and non-traditional supports in care planning while family members are taught how to manage their care, resources and desired outcomes. Parents of SED youth, are employed throughout the community as Family Resource Developers and Child and Family Team Facilitators, providing peer support and resources to family members in need and assisting them in navigating mental health and education systems across the county. A variety of committees have been formed and are meeting with the aim of involving stakeholders in designing effective mental health services which build on the strengths of consumers and address cultural and linguistic needs.

School Sector Coordinators (SSC), who may also be parents of SED youth, are partnered within several local school districts. SSC's help facilitate program access and keep

school personnel linked with vital community resources. McHenry County Family CARE has developed an active Family Council and Youth Council. Both are engaged in social marketing, evaluation, governance and service planning activities.

The Governance Council includes professionals, family members and youth to ensure that the project is family driven, youth guided, culturally competent, and able to shape policies and strategies to improve mental health care and develop a comprehensive system of care for McHenry County. The Governance Council meets on a monthly and quarterly basis with workgroups focused on collaboration, budget, evaluation and sustainability planning. Over the last year, the Governance Council has promoted additional system of care activities through the use of partnership agreements. As Family CARE moves forward, significant effort is placed on enhancing school/mental health partnerships, developing a trauma-informed system of care, collaborative cross-system training and professional development, the development of a local family organization, and cultural competency organizational planning and implementation. The team obtained a suicide-prevention grant from another source to provide suicide-prevention training for system of care families, youth, and partners. This project also focuses on promoting Evidence Informed Practices as it continues to develop

Enrollment in the system of care has been limited to participation in the SASS and Wraparound programs. Over the last year, approximately 300 youth have been served through SASS and 125 youth served through Wraparound. Since October 2006, 83 youth have been enrolled within the National Evaluation. National Evaluation Data has been provided on 69 enrolled youth, 19 of whom have also completed a 6-month follow-up interview. The local evaluation team and Governance Council are beginning to analyze this preliminary data. Respondents on various comparison elements vary from 10-17. Preliminary data shows positive impact on the family's ability to communicate better and work through crisis. Most clinical scales show either very slight improvement or remain stable. School performance and court involvement variables are self-report and also show slight improvement or remain stable. Process evaluation has highlighted the need to expand the continuum of care, continue strengthening the Governance Council, engage more community partners in system of care development, adhere to a logic model/strategic plan and significantly increase the focus on evaluation and continuous quality improvement.

### ***Teen R.E.A.C.H***

This program was developed by the DHS Division of Community Health and Prevention (DCHP) and began in 1998 with approximately \$8.5 million in funding from TANF available through the IDHS as a result of the success of the welfare-to-work program and the national movement to self-sufficiency. By the end of FY2007, this program had grown to an expenditure of \$17 million encompassing 126 community-based agencies which served 29,537 youth between the ages of 6 and 17. The mission of Teen REACH (Responsibility, Education, Achievement, Caring and Hope) is to expand the range of choices and opportunities to enable, empower, and encourage youth from 6 through 17 years of age to achieve positive growth and development, improve their expectations for future success, and avoid and/or reduce harmful, risk-taking behaviors through

educational and prevention services delivered during out of school hours. Teen REACH targets low-income youth, with an emphasis on youth from families receiving public assistance, and youth at risk of dropping out of school or juvenile delinquency. Minority youth represent approximately 84 percent of the participants. This program is the result of collaborative prevention planning which included the DMH and is based upon the realization that structured activities after the school day can mean the difference between success for a young person or the emotional sequel of a life scarred by drugs, gangs, pregnancy, and dropping out of school. Regular participation in Teen REACH appears to reduce violent behaviors while providing regular opportunities to reinforce self-esteem and self worth, as documented by the agencies. This innovative community based after-school program is considered one of the necessary supports to families in achieving self-sufficiency.

In FY 2005, Illinois was awarded a grant under the U.S. Department of Education's Gaining Early Awareness and Readiness for Undergraduate Programs (GEAR UP) initiative. Teen REACH is collaborating with the Illinois' GEAR UP program, which further strengthens Teen REACH as a resource for preparation towards higher education and transition to young adulthood.

---

### ***Illinois Family Partnership Network***

The mission of the Illinois Family Partnership Network (IFPN) is to create greater capacity for developing and supporting family leadership in Illinois. The IFPN is composed of 30 local and statewide organizations as well as state agencies that are committed to increasing family involvement so that outcomes for children can be improved. The vision for the IFPN is that all families are able to support themselves and raise their children in communities that can provide the necessary resources and supports. Understanding that family involvement is fundamental to successfully improving outcomes for children, the DMH participates on the Steering Committee of the IFPN to assist in developing a statewide network of parents, organizations, and state agencies. The Illinois Federation of Families (IFF) is an active participant in IFPN. Through the work of IFPN and IFF the needs of parents of children with serious emotional disturbance can be recognized statewide. Both organizations are exploring ways in which they can collaborate to address the need for advocacy training for parents and to provide information as well as a collective voice with access, support and ownership at the state, regional and local levels. Throughout the state the DMH co-sponsors IFPN conferences that aim to foster children's academic, social and emotional learning through family-school partnerships.

### **Educational Services and Services Provided Under the Individuals with Disabilities Education Act (IDEA)**

#### ***Mental Health and the Schools: System of Care-Chicago***

The Surgeon General's Report on Mental Health states that schools are a major setting for the potential recognition of mental disorders in children and adolescents. Many community mental health agencies, recognizing the critical role a school plays in a child's life, have developed strong working relationships with schools. Ideally, services

should be initiated before there is a mental health problem that interferes with academic success. However, capacity across the array of mental health services, including child psychiatric expertise, is not sufficient to identify, assess and treat children *before* there is a crisis in that child's life. In FY2000, the DMH developed a model for mental health services in schools to address children's mental health needs that are beyond the school's expertise. The model is organized around the needs of the families, schools and communities and includes universal, selected and targeted strategies while addressing cultural factors, stigma, outreach and other barriers to engagement. As a result students experience school wide behavioral interventions that promote learning and provide positive approaches to the task of learning as well as integrated mental health services. The DMH has continued with an expert group to initiate the model that utilizes school consultation teams, offers psychiatric expertise, and expands community mental health capacity to respond to the needs of students and their families. Much of this work has been initiated under the System of Care Grant awarded by SAMHSA CMHS (see also Section III-A, Criterion 3).

### **Juvenile Justice Services**

#### ***Mental Health and Juvenile Justice (MHJJ)***

Youth in the juvenile justice system have disorders that can be effectively treated with psychopharmacological and behavioral interventions. These interventions are usually more successful when they are coordinated with other major service systems impacting the child and family. DMH developed a collaborative project with the juvenile justice system that was initiated in FY 2000. The DMH provides funding for 24 system liaisons who work with detention centers and the courts to identify youth with major affective disorders and psychosis who are exiting from detention and assure linkage with community mental health programs for assessment and treatment. Each liaison serves approximately 50 youth and their families per year. This initiative strengthens the linkages among the courts, probation, detention, the schools, mental health, health and other community-based services. When the community mental health services are in place to address the clinical needs of the youth, the liaison can also access wraparound funds to accommodate supports for the youth.

### **Substance Abuse Services**

#### ***Services for Youth with Co-Occurring Disorders***

As part of assessment at intake, mental health staff track the proportion of children and adolescents who are dually diagnosed with mental health problems and substance abuse (*see Performance Indicator C3.6*). As reported above, relatively few children are identified (a little over 1%). DMH C & A program staff in collaboration with the DASA continue to explore the need for staff training and current program capacity issues in clinically addressing the needs of this population.

### **Health and Mental Health Services**

#### ***Access to Health Care:***

Collaboration with the Department of Healthcare and Family Services supports access to healthcare programs which ensure access to health care for children and adolescents: ALLKIDS, an expansion of the previous KidCare program, was implemented in July 2006. See above-Criterion I.

### ***Community Health and Prevention***

Collaboration between the DMH and the Division of Community Health and Prevention (DCHP) is addressing two arenas: (1) Mental health services to families that have experienced domestic violence; (2) Identification of children's mental health needs in child care settings. The DMH participates in the quarterly meetings of the DCHP Healthy Child Care Illinois initiative and contributes to the development of the initiative's annual meetings in which nurse consultants from around the state came together to discuss the mental health needs of children in child care settings. Additionally, the DMH is collaborating with DCHP and the members of the Postpartum Depression Task Force to address the needs of women who experience depression during pregnancy and postpartum.

### ***Community and Residential Services Authority***

Since 1986, the DMH has been an actively participating member of the Community and Residential Services Authority (CRSA), which was created in 1985 by the Illinois General Assembly. The membership of the Authority includes child-serving state agencies, education, public and private sector gubernatorial appointees and members of the General Assembly. CRSA combines interagency deliberations to resolve multiple agency disputes and to plan for a more responsive, efficient and coordinated system to address the needs of children and their families. Many of the children who experience behavior disorders or severe emotional disturbances have multiple and diverse service needs which do not clearly fit the service eligibility criteria or funding streams of state and local public agencies. CRSA successfully negotiated the participation of eight state human service agencies in a pooled fund which is used to carry out an inter-agency service plan when children and families are unable to fully qualify for services from a state agency.

### ***Illinois Children's Mental Health Partnership (ICMHP)***

The Children's Mental Health (CMH) Act of 2003 created the Illinois Children's Mental Health Partnership (ICMHP). The Partnership is charged with developing a Children's Mental Health Plan containing short-term and long-term recommendations for providing comprehensive, coordinated mental health prevention, early intervention and treatment services for children from birth to 18. The ICMHP is comprised of members of child-serving agencies and other mental health system stakeholders including parents of children with emotional and serious emotional disturbances. DMH Child and Adolescent Service System staff are active members of the ICMHP and are active partners in promoting its vision.

The ICMHP has been successful in garnering state funds for children's mental health needs. The DMH Child and Adolescent Office works closely with the ICMHP in planning how the funds are to be used and implementing those plans. In FY2008,

ICMHP obtained a \$6.5 million budget which included funding for the expansion of key projects in services to transitioning youth, early childhood consultation, and early intervention. Five new pilot projects were initiated statewide to provide transitional services for older adolescents (16-17 years old) who are transitioning from C&A services to adult services and for any youth with SED transitioning from correctional services to the community. The projects provide direct basic services and serve to build the infrastructure for continuing expansion and service effectiveness. These programs are providing vital information as to the kind of models which work best in serving these two transitional groups. An Early Intervention Initiative provides a granting opportunity to selected DHS agencies in each region. The aim is to outreach in venues which are outside the normal service paths for children with serious disturbances, identify children at risk, especially those at risk of depression, and to intervene early. Flexibility is being emphasized as each agency develops its own plan and approach to early intervention based on the unique geographic, cultural, and interagency service environments in each region. By the end of FY2008, two agencies in every region will be in a position to coordinate early intervention services. Additionally an Early Childhood Consultation program was expanded statewide in FY2008 to engage consultants who travel to the selected agencies and provide case consultation, education in early childhood issues, and training to identified agency staff for a period 12-18 months. Agencies successfully completing the training and consultation program will receive funds to expand their services and provide support to other agencies in their area which are developing this specialization. Plans for these initiatives are addressed more fully in Section III.

#### **CRITERION 4: Targeted Services To Homeless And Rural Populations.**

##### **The Homeless Population in Illinois**

The IDHS Emergency Food and Shelter (EF&S) program issues an annual report that reviews trends in services provided to homeless persons in Illinois. **See this Criterion in the Adult Plan.**

##### **Outreach to Homeless Youth and Families**

The most frequent cause of homelessness as reported by homeless adults is income. In 2007, the proportion of the caseload attributing homelessness to income problems was 38% among the population served by the state's Emergency Food and Shelter (EF&S) population. Income as a precipitator of homelessness ranged from 29% for households of females with children to 41% for homeless couples with children. Eviction was the most common reason given by these households as the primary cause of their homelessness. Over 20 percent (6,778) of homeless households cited reasons for homelessness related to family and neighborhood such as overcrowded conditions, domestic violence, gang violence, and disputes with neighbors and landlords. Nearly one third of these households (2,162) were single females with children. In FY 2007, 6,500 households with children accounted for 13,224 participants under the age of 18 (29% of the total served) of which

50% (6,569) ranged from newborn infants through five years of age. Combined with the 18 through 21 year old group (2,697) nearly 33.4% of the homeless persons served by the EF&S program were under the age of 22.

Mental health planning and services to homeless youth is complicated by the inherent invisibility of this population as well as the priority of meeting their basic needs when they are reachable. Likewise, homeless families are not exempt from the problems presented by their children with severe emotional disturbance but these are often overshadowed by the urgency of meeting the family's survival needs. Over the years, workgroups have been convened which consisted of homeless youth service/shelter providers and DMH-funded mental health providers to identify barriers to effective services for this client group. The IDHS maintains services to homeless youth who are 20 years of age or younger and cannot return home and/or lack the housing and skills necessary to live independently. The Homeless youth program is administered by community-based agencies and is available in six Illinois counties and the city of Chicago. The IDHS-funded programs provide these important services for homeless youth:

- **Emergency shelter:** Either through placement in a shelter, group home or by purchasing lodging, youth are given a safe, clean, dry place to sleep.
- **Transitional services:** Focus on skills necessary to support oneself, including education, employment services, and subsidized housing.
- **Drop-in center/outreach:** Programs seek to find homeless youth and assess their needs. Program staff may attempt to reunite them with family or refer them to transitional services.
- **Services for singles:** Single programs serve youth who do not have children.
- **Services for pregnant or parenting youth:** Programs specialize in the needs of homeless youth with children.

In FY2007, 21 Homeless Youth providers served approximately 650 youth, ages 14-20 in their emergency shelters and transition living programs. An additional 55 youth were reportedly served in the Homeless Youth Outreach programs across the state. The program was funded at \$4.7 million in FY2007. Each youth is assessed for needs and strengths and a case plan is developed for service provision which includes case management, provision of food and shelter, life skills training, employment assistance, advocacy, education assistance, and parenting skills. Mental health services are accessed when needed.

Homeless youth/shelter providers have worked successfully with mental health service providers in several areas of Illinois. SASS agencies in Rockford and East St. Louis continue to work closely with shelters, usually providing an initial mental health assessment, crisis intervention service, and mental health case management.

#### ***Services In the Metropolitan Chicago Area:***

Services to homeless youth and their families are being addressed in the Urban Systems of Care (USC) initiative which was previously described (See Criterion I above). Collaboration between Urban Systems of Care homeless providers and citywide homeless services providers has been essential to examine the array of necessary supports available

to reduce the risk of homelessness. USC providers and city-wide homeless services providers routinely coordinate their efforts at addressing this population.

Beacon Therapeutic Center's Shelter Outreach Services (S.O.S.) program utilizes a preventive model which focuses on intervention with children and parents in the shelter setting and provides targeted case management and mental health services to women and children in ten shelters on the south, north, and west sides of Chicago. Services focus on the identification of untreated mental illness, developmental delays, substance abuse, needs assessment, advocacy, coordination services and follow-up supportive services. Funding for the expansion of the S.O.S. program to include youth and families at four of the City of Chicago Warming Centers has occurred. Mental health services are intensive and include crisis services, assessment, referral and linkage. All services are community based and linkages are made with programs designed to intervene with young children. The principal intervention team includes a qualified mental health professional and case manager. Ancillary staff includes a child psychiatrist, a speech and language therapist and other mental health.

This program is exemplary in that it has actively focused available resources to meet the needs of the homeless children it serves. S.O.S. works closely with two universities to bring clinical resources to homeless young children. The University of Illinois Department of Psychiatry assigns psychiatrists doing their residency to the program on an ongoing basis to provide psychiatric evaluations and consultation. The Department of Developmental and Behavioral Pediatrics of the Pritzker School of Medicine, University of Chicago, works closely with the program to provide developmental and pediatric health evaluations. The United Way has provided funding to establish a "medical home" model of service for the children aged 3 to 5 and their families in the program. This has resulted in outreach to homeless families with young children requiring medical care and referral and linkage with health providers who follow up on the health needs of the child. The program participates in a group of nine providers statewide who are receiving early childhood consultation services (See Objective C3.5 in Section 3) which has allowed for some sharing of interventions and approaches unique to homeless children with mental health providers. Beacon Therapeutic School's Shelter Outreach Service reports that it served 1400 (rounded figure) homeless children in 600 homeless families residing in Chicago shelters during FY2006. The program found and secured appropriate permanent housing for 300 families through its case management services.

### **Rural Mental Health Services - Youth and Their Families**

The term "rural" in Illinois is used to refer to residents in 76 non-Metropolitan Statistical Area (MSA) counties and residents not in municipalities of 25,000 or larger. (Rural Revitalization: The Comprehensive State Policy For the Future, Governor's Rural Affairs Council, April, 1990 pp. 2-4) Based on Illinois' definition of rural areas, 76 non-metropolitan counties are being targeted for assessment of the mental health needs of residents, evaluation of current services and programs, and the identification and eventual resolution of problems in service delivery unique to rural environments. The DMH is a member of the Governor's Rural Affairs Council and provides the mental health perspective on rural issues. The Council provides an opportunity to network with a

variety of state government agencies and community institutions, which can support mental health services for youth in rural areas.

### **Available Services In Rural Areas**

#### **Team Illinois**

DMH participates in a broader DHS initiative addressing the multiple challenges posed by providing services in rural areas. Team Illinois continues to be a priority initiative of Illinois Governor Rod Blagojevich and his administration. The goal of the program is to demonstrate that by partnering with local residents, elected officials, and other stakeholders in communities that face multiple challenges, and by concentrating its resources in these communities, the State can help communities build stronger infrastructures, achieve economic turnaround and create a foundation for future growth. Team Illinois is an unprecedented effort to pool and focus Illinois resources, create public-private partnerships and collaborate with local citizens and community stakeholders in areas with a demonstrated need for infrastructure and economic development. Virtually every State agency is a partner in Team Illinois and has something to offer communities in need of intensive services. In each community, representatives of several state agencies participate in workshops, meetings, interviews and one-on-one discussions with local citizens and leaders as part of a needs assessment and to exchange ideas for addressing these needs. The state resources and partnerships put in place by Team Illinois will be long-term and the initiative will remain in the community as long as necessary.

The establishment of SASS programs in rural areas has addressed the need for family-based crisis intervention and intensive mental health services to rural families and has been of inestimable value to families of youth with serious emotional disturbances. Since FY-1997, when SASS services were made available in all 76 rural counties through the addition of 23 new programs in Southern Illinois, the problem-solving encountered by SASS programs and the local area networks in these areas in delivering services has provided valuable information for strategic service planning of services in rural settings. Accompanying the SASS expansion in the rural areas of Illinois, the CCSR serving these areas have undertaken the planning and coordination of services for families with children and youth having serious emotional disturbances. Agencies that were pocketed in isolation now network with other child-serving agencies. There has also been increasing emphasis on the unique and central function of schools as networking partners in the process of improving access and availability of services to rural families

### **Criterion 5. Management Systems**

The DMH continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those responsible for emergency health services regarding mental health. In this section, initiatives to enhance financial resources and human resources for children and adolescents including significant

achievements are described. There is also a brief analysis of the systems strengths, needs and priorities.

### **Enhancing Financial Resources**

#### **Increased Financial Resources For Community Services**

See Section II, Criterion 5 of the Adult Plan for a discussion of this topic which is applicable to both adults and children.

#### *Increased Financial Resources For The Child And Adolescent Population*

In FY-1996, with the redirection of funds from inpatient care to community-based services, \$7,146,521 was spent on SASS programs, including service expansion in Central Illinois. By FY-1997, with further enhancement, SASS programs covered a geographic area that included 100% of the State's child and adolescent population. \$8,697,743 was provided. In FY-1999, the budget included \$10,612,300 based on the redirection of funds gained from the closure of the metro C&A facility. These funds were allocated to purchase community-based hospital care, expansion of community-based outpatient and SASS services, and the establishment of the Urban Systems of Care initiative, which targets youth of the Chicago Housing Developments.

Other efforts have increased the financial resources available to support service delivery to children and adolescents and their families. The System of Care Chicago Project funded by SAMHSA for \$9.5 million dollars, which was described in a previous section of this application, has brought a great deal of resources into the state over the last 5 years. Statewide C&A Regional staff also collaborated with three counties (McHenry, Champaign and St Clair) to submit three new applications for System of Care grants. The McHenry County application was funded, thus new additional Federal dollars are now available for the child and adolescent system of care.

### **Increasing Federal Financial Participation (FFP)**

See Section II-Criterion 5 of the Adult Plan for a review of this topic which applicable to both adults and children.

### **Enhancing Human Resources**

#### **Staff Recruitment and Retention**

Human resource development is a critical aspect of community-based services for both adults with serious mental illnesses and children with serious emotional disturbances and their families. A discussion of this area applicable to both children and adults is to be found in Section II-Criterion 5 of the Adult Plan.

### **Mental Health and Law Enforcement Training**

The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis. This training is applicable to both adults and children and a descriptions can be found in Section II-Criterion V of the Adult Plan.

## **Human Resource Development Related To Child And Adolescent Services**

In FY-1999, the DMH contracted with the University of Illinois at Chicago Department of Psychiatry to oversee the implementation of a Statewide Child and Adolescent Training Initiative. The initiative was funded and implemented in FY-2000. Training occurred statewide with national experts presenting state of the art practice in the delivery of services to youth with serious emotional disturbance. The content was geared towards the needs of mental health providers, which were determined in a comprehensive survey. The continuation and recent activities involved in this initiative are described in Section III.

### **Strengths, Needs and Priorities**

#### **Criterion 1**

Important strengths are:

- ✓ The array of core services that are available to youth with serious emotional disturbances and their families.
- ✓ The commitment to evidence informed practices that lead to resilience and a focus on recovery by mental health system stakeholders.
- ✓ Planning for family driven care based on the goals identified by the President's New Freedom Commission which serves as the foundation for current and future planning efforts.
- ✓ A commitment to the dissemination of information regarding the implementation of evidence-based practices as evidenced by work that is occurring within the System of Care Initiatives, and through partnerships with the Children's Mental Health Partnership.
- ✓ The Governor's state health care coverage program that offers comprehensive, affordable health insurance for children in Illinois assures that every uninsured child, regardless of income or medical condition has access to health care, including mental health services. Additionally healthcare coverage is extended to parents living with their children 18 years old or younger and relatives who are caring for children in place of their parents.
- ✓ Collaborative efforts, pilot projects, and vocational/employment supports to address the needs of youth with serious emotional disturbance transitioning to adulthood, including those transitioning from correctional settings and the child welfare system.
- ✓ The Statewide DMH Child and Adolescent Program has established a Teen Advisory Group composed of adolescent consumers that continues to provide input on the planning and delivery of services.
- ✓ Family Resource Developer positions have been created and maintained across the state (See Section III-A) and have also been an active component of the System of Care initiatives.
- ✓ The consistent commitment and ongoing efforts to divert children and adolescents from inpatient and residential treatment to services in their home communities as exemplified by the SASS (Screening, Assessment and Support Services) program

and the DMH Individual Care Grant (ICG) Programs. These individualized ICG or SASS services include intensive home-based support, treatment and respite care which allow the child to remain at home.

## **Criterion 2**

### **Strengths, Needs And Priorities**

Important strengths of Illinois' community-based mental health system as described under Criterion 2 include:

- ✓ Implementation of a clinical outcomes analysis system for children/adolescents which can generate multi-level data reporting (see above and Section III-A). Additionally, the joint work with the newly established MHCAC on a data warehouse will provide improved and expanded access to data which is vital to support decision making in children's services.
- ✓ Since FY 2006, all individuals seeking mental health services are assigned unique ID numbers which are also being assigned to consumers who access services under other Divisions within DHS, as well as to individuals receiving services through the Child Welfare System. This will lead to improved tracking of services received by consumers across state systems, as well as increased accuracy in unduplication of consumers receiving services in the mental health system.
- ✓ The DMH has an extensive array of computerized information that provides an important resource for analyzing service provision and service needs.
- ✓ Through federally funded studies and DMH initiatives, our databases and analytic capabilities have steadily grown.
- ✓ The Reporting Of Community Services (ROCS) provides data as to the types of services provided for children/adolescents as well as the number of persons served.
- ✓ External resources, such as the Data Infrastructure Grant have continued to assist MIS development and system analysis which remain an important DMH priority.

## **Criterion 3**

### **Strengths, Needs and Priorities**

The strength of the DMH service delivery system for children and adolescents is multifold, and is based on collaboration with IDHS Divisions and free-standing state agencies to ensure continuity of care and service integration:

- ✓ The on-going collaboration with the Children's' Mental Health Partnership has been fruitful in providing the resources needed to advance several vitally needed initiatives including services to youth in transition, early intervention, and the promotion of Evidence Informed Practices.
- ✓ The statewide Mental Health Juvenile Justice (MHJJ) program which brings services to youth in county detention centers across the State is a collaboration between juvenile justice and DMH.

- ✓ Long-standing collaborations are in place with the DCFS, the ISBE and the DASA. The DMH has partnered with these agencies to implement the wraparound approach to the delivery of children's services as well as to provide or coordinate delivery of mental health services.
- ✓ More recently, a collaboration with DCFS and DHFS have expanded the provision of SASS services.
- ✓ The Mental Health in Schools Model, that strives to strengthen inter-agency collaborations using the school as a setting for prevention, early identification, and intervention activities. This approach is being extended in several areas of the state through federal funding from SAMHSA.

#### **Criterion 4**

##### **Strengths, Needs and Priorities**

In addition to the broader strengths noted in the Adult Section 2, there are several specific strengths to be noted for children and adolescents in this Criterion:

- ✓ The DMH has put in place outreach services for homeless children and youth. Beacon Therapeutic Center's Shelter Outreach Services (S.O.S.) program utilizes a preventive model which focuses on intervention with children and parents in the shelter setting and provides targeted case management and mental health services to women and children in ten shelters on the south, north, and west sides of Chicago. Services focus on the identification of untreated mental illness, developmental delays, substance abuse, needs assessment, advocacy, coordination services and follow-up supportive services.
- ✓ The IDHS Homeless Youth program which has existed for many years provides outreach and a range of services for homeless youth ages 14-21.
- ✓ In rural areas, SASS programs continue to work closely with community providers to enhance service delivery for children and adolescents.
- ✓ Innovative approaches that integrate DMH services with rural schools have been developed.
- ✓ Public Act 95-16 signed by the Governor in July, 2007 that gives Illinoisans living in rural communities increased access to psychiatric care by requiring the Illinois Department of Healthcare and Family Services to reimburse psychiatrists and federally-qualified health centers (FQHCs) for mental health services provided via telepsychiatry. DMH is planning to move forward to provide child psychiatry consultation and services through telepsychiatry in Region 4 and Region 5 which are very rural. Six agencies will be selected to study and report on what would be needed to carry out a telepsychiatry program effectively.

#### **Criterion 5**

- ✓ The DMH has made a substantial, successful and sustained commitment to increasing the portion of the DMH funds allocated to community-based treatment for children and adolescents with serious emotional disturbance and their families.

- ✓ In recognition of the increasing role played by federal Medicaid funds, the DMH has worked successfully to increase this revenue source to benefit childrens' services.
- ✓ The DMH has maintained a strong joint public and academic program which continues to include Departments of Psychiatry, Social Work, Psychology, and Nursing in universities across the State as evidenced by specialization and curricula appropriate to children with SED..
- ✓ Innovative directions in the use of limited fiscal resources to promote expansion and growth of needed services geared to children and families such as initiating a fee-for-service payment mechanism to purchase services for individuals from community mental health agencies.

# Illinois

## Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

The information provided in the adult section of the plan pertains to adults and children. Please see the referenced section.

# Illinois

## Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

## **DMH Priorities and Plans to Meet Service Needs and Gaps**

### **Criterion 1**

- Continued expansion of the scope and quality of parent and youth involvement remains a priority. Family involvement continues to emerge as a gathering strength in the C&A community service system as well as in successful inter-agency collaborations.
- The development of early intervention programs and collaborative initiatives for children of all ages is a major priority of the Statewide C&A Services Office as is the promotion and growth of early childhood consultation in the State designed to support and strengthen services to very young children.
- Another concern is the need to enhance family involvement in the development and implementation of individualized treatment plans for children and adolescents receiving mental health services.
- Inter-agency collaborations have been an important support and strategy for the DMH in improving services for children and adolescents. The DMH has an active collaboration with the Children's Mental Health Partnership to implement Evidence Based Practices. The DMH also has strong and improving initiatives in collaboration with other agencies including the juvenile justice system, mental health services in schools, and the substance abuse service system to address co-occurring mental illness and substance abuse disorders, and the child welfare system. These initiatives respond to ongoing needs and will remain a priority.
- Activities aimed at reducing hospitalization and out of state residential treatment have been successful. Screening through the SASS program and crisis services have contributed to this success. Case management services, Wraparound services, and ICG/MI community services also help to reduce hospitalization and residential treatment while providing ongoing clinical care and linkage to supportive services in the community. These services will remain a high priority for DMH.

### **Criterion 2**

The DMH places a high priority on the maintenance and improvement of its management information systems to meet the challenges ahead. This work has been valuably supported by the requirements and activities undertaken through the Data Infrastructure Grant.

### **Criterion 3**

The service system priority continues to be one of collaboration to provide a seamless system of care, given the multiple problems of children and adolescents, as well as their families, who are involved with overlapping service systems. The expansion of Mental Health in Schools and Systems of Care such as McHenry county's model is an important need and priority. The DMH is continuing to focus on the implementation of evidence-

based practices for children. Additionally, the C&A statewide office is undertaking joint work with DCFS toward the continuing education of mental health providers on addressing trauma issues. Collaborative efforts with Children's Mental Health Partnership, DHFS, and the IDHS Community Health and Prevention Division (CHP) to develop consultation approaches and promote evidence informed practices are an active priority.

#### **Criterion 4**

The FY2006 EF&S Report clearly points to the principal priority of DMH. One third of the homeless population (which were served by EF&S) were under the age of 18. New and expanded service models and implementation are required to meet the needs of this population. Existing programs and service models such as Beacon Therapeutic School's Shelter Outreach Service require statewide replication and continuing expansion.

A DMH survey found that major concerns across rural counties include the need for transportation and for "one-stop" services shopping. These concerns suggest the need for a broader partnership among state agencies. Initiatives with universities located in rural areas such as Southern Illinois University (SIU) are aimed at developing strategies to better align service delivery for children and adolescents in rural areas. Other approaches, including video-conferencing and telepsychiatry are assertively advanced and increasingly utilized.

#### **Criterion 5**

- Like many states, Illinois has experienced fiscal problems in recent years, leading to decreases in allocations for human services. There is therefore an even greater need to increase revenue from federal Medicaid funds.
- The development of alternative cost efficient training supports remains a priority. The DMH does not have dedicated resources for a training department of its own and fiscal problems have resulted in the cancellation of several training contracts in the past few years.
- Training events that assist in the implementation of evidence-informed practices continue to be a priority of DMH.
- In the wake of 9/11, the DMH has recognized the need for a statewide mental health plan for responding to terrorist activities, as well as natural and other disasters.

# Illinois

## Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

The significant achievements described in the adult section of the plan pertains to adults and children. Please see referenced document.

# Illinois

## Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

The Illinois vision for the mental health system described in the adult section pertains to adults and youth. Please see this section as referenced.

# Illinois

## Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

## **ADULT PLAN**

### **SECTION III-A: PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM**

#### **Criterion 1. Comprehensive Community-based Mental Health System**

##### **Consumer Involvement/Participation**

The provision of mental health care that is consumer and family driven is an important priority of the Illinois Division of Mental Health. This priority is consistent with the President's New Freedom Commission recommendations to involve consumers and families in orienting the mental health system towards recovery, and to improve access to, and accountability for mental health services. Several years ago, in an effort to create uniformity in consumer participation across the state, the DMH Office of Recovery Support Services working in collaboration with DMH Regional Managers and recovery support specialists, developed a statewide consumer participation plan. The plan was founded on the identification of successful practices in various parts of the state that have led to increased consumer participation. These practices were incorporated into the strategic planning efforts of the DMH regions. A variety of initiatives have been implemented to support consumer participation.

##### **Mental Health Planning Advisory Council**

A concerted effort has been made to ensure that consumers and family members play an important role in planning for mental health services. Representation by consumers and parents of children with serious emotional disturbances has increased. Consumers and/or family members co-chair the MHPAC, as well as all MHPAC sub-committees.

##### **WRAP Initiative.**

Under the leadership of the DMH Director of the Office of Recovery Support Services, the Wellness Recovery Action Plan (WRAP) model has been adopted by Illinois. A statewide WRAP steering committee meets on a monthly basis to plan and review progress on the WRAP initiative. Through the establishment of WRAP classes in community agencies and the introduction of the principles of WRAP at consumer forums and conferences, thousands of consumers throughout the state have benefited from receiving orientation and education in the principles and components of this emerging best practice in recovery-based services. Since the inception of the Wellness Recovery Action Plan (WRAP) Initiative in Illinois in FY2003, over 200 individuals (including consumers currently receiving services) have received Certificates as WRAP Facilitators through their completion of a 40-hour intensive course. Refresher/Continuing Education courses are held in each region bi-annually for Certified WRAP Facilitators.

In FY2008, a statewide survey of all certified WRAP Facilitators was conducted. The purpose of the survey was to identify the percentage of trained facilitators who were facilitating WRAP classes, and the best means to support them. The preliminary findings of the survey have been utilized to address the stated needs of the facilitators through the ongoing development and delivery of continuing education/refresher courses and by hosting a bi-monthly conference call for facilitators.

### **Consumer Conferences.**

DMH Recovery Support Specialists work with stakeholders to design, plan and convene annual consumer conferences in each DMH region. These conferences often have a well-known and /or national speaker who delivers the keynote address and who sets the "tone of recovery" for the conference. Consumer education is provided through a variety of venues in the state. Eight regional conferences were held across the state during FY2008. Hundreds of consumers, family members, providers, DMH and other state agency staff attended these conferences.

Consumer participation objectives for FY 2009 support the DMH priority for furthering work on the recovery vision in Illinois by encouraging consumers and family members to participate in decision-making and service planning. Some of these objectives are continuations of efforts initiated in prior fiscal years.

**Objective A1.1: Continue enhancement of the statewide system to educate consumers of mental health services in leadership, personal responsibility and self-advocacy through participation in Consumer Conferences, the use of Wellness Recovery Action Plans (WRAP), and through the Consumer Education and Support Initiative.**

#### **Indicators:**

- Number of Regional consumer conferences held.
- Number of Certified WRAP Facilitators reached through statewide survey project.
- Number of participants in the quarterly regional WRAP continuing education/refresher trainings conducted in FY2009.
- Number of participants in Consumer Education and Support teleconferences.

### **Consumer Education and Support.**

Dissemination of accurate information regarding services for consumers is the primary focus of the Consumer Education and Support Initiative, begun in FY2007 as an outgrowth of the DMH System Restructuring Initiative (SRI). DMH has recognized the need for providing consumers with the tools they need to cogently and effectively participate in the development and evaluation of the service system. The goal of this project is to ensure that consumers of mental health services receive current, accurate and balanced information regarding changes in the service delivery system, empowering them to take an active, participatory role in all aspects of service delivery. In FY2008, Block Grant funds were expended to conduct pre-arranged conference calls with consumers in all parts of the State. Eight statewide calls were held for consumers (see list of topics below), with the number of participants ranging from 325 – 700<sup>1</sup>. These calls provide a

---

<sup>1</sup> July: The Role of the New Mental Health Services in Facilitating Recovery & Resilience

August: The Role of Peer Support in the New Mental Health Services

September: Changes in Mental Health Services

October: Certified Recovery Support Specialist (CRSS): Understanding the What, Why and How of the New Credential

forum for discussion of service information, performance data, new developments, and emerging issues to promote consumers' awareness and knowledge.

**Objective A1.2:** In FY2009, the DMH Office of Recovery Support Services will conduct a series of conference calls designed to disseminate important information to consumers across the State.

**Indicators:**

- Number of conference calls completed in FY2009.
- Number of participants in Consumer Education and Support teleconferences.
- Amount of block grant funds allocated for this purpose.

**Specialized/Targeted Efforts Related to Recovery**

**Certified Recovery Support Specialist (CRSS).**

In collaboration with the Illinois Certification Board (ICB), the Divisions of Mental Health, Rehabilitation, and Alcoholism and Substance Abuse have developed the Illinois Model for Certified Recovery Support Specialist (CRSS). The CRSS, through collaboration with the ICB, is now competency-based rather than curriculum-based. Individuals are certified as having met specific predetermined criteria for essential competencies and skills. The purpose of certification is to assure that individuals who meet the criteria for CRSS provide quality services. The credentials granted through the certification process will: (1) be instrumental in helping guide employers in their selection of competent CRSS professionals, (2) define the unique role of CRSS professionals as health and human service providers and (3) provide CRSS professionals with validation of, and recognition for their skills and competencies. Access to this new credential became available through the ICB beginning in July of 2007.

As a means of disseminating information regarding this new credential, one statewide call for consumers was dedicated to this topic. Additionally, the ICB has provided staff presence at each of the regional consumer conferences, to distribute information and respond to questions. Individuals attending consumer conferences, including the statewide consumer education and support teleconferences, receive CEU's toward their credential through the ICB.

In FY2009, the Office of Recovery Support Services will work with other system partners, including the ICB and the Mental Health Collaborative for Access and Choice (MHCAC), to develop training and study materials for those seeking to obtain their CRSS. Additional information regarding this cutting edge approach in credentialing for

---

November: Access and Choice: How the state will change the management of mental health services to ensure you're getting the right services, in the right amount, at the right time

February: An Overview of Wellness Recovery Action Planning (WRAP)

April: Recovery Strategies for Combined Mental Illness & Substance Use Disorders

May: Crisis Plans - Making Choices for Difficult Times

mental health peer specialists can be found at  
[http://www.iaodapca.org/forms/crss/CRSS\\_Model.pdf](http://www.iaodapca.org/forms/crss/CRSS_Model.pdf)

### **Recovery In-service Training**

**Objective A1.3:** In FY2009, continue to provide recovery oriented training to all interested stakeholders and support the role of Certified Recovery Support Specialists (CRSS).

**Indicator:**

- Number of recovery oriented training sessions provided to stakeholders.
- Number of individuals obtaining the CRSS credential.

### **Adoption and Implementation of Evidence-Based Practices**

Despite the existence of a wide range of clinical treatments and programs with strong empirical support, research suggests that access to these services in the community is quite limited. In recognition of this issue, the President's New Freedom Commission on Mental Health has noted the importance of expanded implementation of evidence-based practices. The DHS Division of Mental Health aims to provide excellent mental health care that maintains and expands access to effective mental health services, and in particular to evidence-based practices (EBPs) and best practices. Efforts are underway to pilot each of the adult EBPs identified by SAMHSA.

In July 2007, the DMH convened a statewide conference, entitled Evidence-Based Practices in Illinois: A State of Change. Experts on each of the EBPs made presentations on focusing on implementation, organizational and financing issues that should be taken into consideration when planning for implementation. Approximately 300 individuals (consumers, family members, advocate, providers and state agency staff) attended the two-day conference. Efforts to address SAMHSA's National Outcome Measure of Implementing Evidence-Based Practices will continue in FY2009.

### **Permanent Supportive Housing**

Permanent Supportive Housing is a specific Evidence Based program model in which a consumer lives in a house, apartment or similar setting, alone or with others (upon mutual agreement – no more than two consumers within a common unit). The criteria for supportive housing include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability. Housing should be integrated and affordable (consumers pay no more than 30 % of their income on rent). Ownership or lease documents are maintained in the name of the consumer.

Illinois has been consistent in efforts to develop housing options and support services for individuals with serious mental illness. The goal of this initiative is to promote and

stabilize consumer recovery by providing decent, safe, and affordable housing opportunities linked with voluntary DMH-funded community support services. A key component to the success of this effort is the creation of a new DMH Bridge Subsidy Program that will provide tenant based rental assistance opportunities to high priority consumers who can and should be living in their own housing units in the community. The Bridge rental subsidy is designed to act as a “bridge” between the time the consumer is ready to move into his or her own housing unit until the time he or she can secure a permanent rental subsidy, such as Section 8 Housing Choice Voucher or comparable rental subsidy. To facilitate transition to a permanent voucher from the Bridge Subsidy Program as seamlessly as possible, the requirements and guidelines for the program are consistent with those of the Housing Choice Voucher (HCV) Program and the consumer must either already be on a Public Housing Authority (PHA) waiting list for a Section 8 HCV or agree to register/apply for a HCV or comparable subsidy and to accept the subsidy whenever the opportunity is available. Consumers who have a serious mental illness or a co-occurring mental illness and substance abuse disorder whose household income is at or below 30% of Area Median Income (AMI) as defined by HUD are eligible to apply to the program. DMH is currently targeting a defined population of consumers, including: those in long term care facilities or at risk of being in a nursing facility, long-term patients in state hospitals, young adults aging out of the ICG/MI program or out of DCFS guardianship, residents of DMH funded supported or supervised residential settings, and those who are determined by DMH to be homeless.

**Objective A1.4: By the end of FY2009, through the provision of rental subsidies, implement a statewide permanent supportive housing initiative which targets 150 consumers acquiring decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice.**

**Indicators:**

- **Number of consumers who acquire appropriate permanent supportive housing through the DMH Bridge Subsidy Program in FY2009.**
- **Number of DMH selected Bridge Subsidy Administrators established and functioning in the state by the end of the fiscal year.**
- **Number of DMH-funded providers participating in the program.**
- **Amount of money expended for the program in FY2009.**

**Medication Algorithms**

The Center for the Implementation of Medication Algorithms (CIMA) is a DMH-funded initiative to disseminate empirically informed medication algorithms, patient and family education, and outcomes assessment systems that support the psychopharmacotherapeutic treatment of schizophrenia, major depression, and bipolar disorder, consistent with recommendations of the President's New Freedom Commission on Mental Health. Since its inception in July 2004, CIMA has provided education, implementation planning, and clinical training to personnel in mental health treatment agencies across the state using a three-stage education model. Level 1 Education introduces and informs potentially interested service providers about the role of CIMA and how agencies can participate in the project. Level 2 Planning, the second stage of engagement, involves meetings with specific, interested agencies. An assessment is made to determine what changes are

required for the conversion of existing service delivery practice to the use of medical algorithms. Level 3 Training is the actual clinical training of agency personnel in the use of the algorithms, outcomes, and education components of implementation.

The primary objective of the program during FY2008 was to continue and increase training and implementation of medication algorithms as indicated by the number of agencies completing training at each level. In addition, increasing engagement of State Operated Hospitals and affiliated Community Mental Health Centers was specifically targeted. Progress toward this objective has been made in the past fiscal year. Level 1 Education was conducted in several venues and now has been done in over 40 agencies. Ten Level 2 Planning sessions were conducted across seven agencies and five Level 3 Training sessions were conducted across four of those agencies.

A primary focus this year was to move State Operated Hospitals (SOHs) and at least one Community Mental Health Center (CMHC) associated with each hospital through stages to Level 3 Training in at least one of the three algorithms. To date, five of seven SOHs have completed Level 3 Training in at least one algorithm. One of two Forensic SOHs completed Level 3 Training this past year. However, engaging CMHCs associated with the civil units of SOHs has been a challenge this past year due to coordination issues and lack of agency interest. Three agencies in the Greater Chicago and Western Suburban areas have undergone Level 3 Training and one is currently at Level 2 Planning. CMHCs in the Rockford area are currently between Level 1 to Level 2 stages. During FY 2009, CIMA will focus particular energy on engaging more community based service agencies that are associated with the hospitals. For effective algorithm implementation and continuity of care, further work is needed to bring CMHC engagement on par with that of the SOHs. Medical leadership and support at the state level (DMH) and at the agency level appears very important to implementation success. Changes and loss of medical leadership at some agencies and in DMH facilities have been obstacles to engagement. The primary obstacle preventing new CMHCs from engaging in this project appears to be a lack of incentive to adopt evidence-based practices over what they currently practice. Data on the cost-effectiveness of algorithm use was recently published and has been incorporated into the training program. Demonstrated cost savings and increased revenue for CMHCs who use algorithms, person-to-person communication between CIMA and the leadership of CMHCs, as well as support from the Clinical Director's office of DMH, are helpful incentives to engage some agencies.

Principals from the CIMA made several presentations to small and large groups across the State this year including in Rockford, Ottawa, Chicago, Arlington Heights, Springfield, and Peoria. The new website that provides downloads of educational and other materials that support algorithm use is available at <http://www.uicomp.uic.edu/dept/psychiatry/CIMA/index.shtml>. It is accessible, but is currently being modified to fit a new format implemented by the university this past year. Additionally, the CIMA Advisory Committee, which updated all of the algorithms last year, lost several members, is being restructured, and interest from recognized experts in the pharmacology of the primary disorders targeted by the algorithms is being solicited for participation on the Committee.

CIMA is planning to work on addressing these issues and increasing participation by agencies in this dissemination project. Accordingly, the objectives of the program for FY2009 are as follows:

**Objective A1.5: (a) Continue and increase training and implementation of medication algorithms as an evidence-based practice. (b): Continue and increase the training of State Operated Hospitals and affiliated Community Mental Health Centers.**

**Indicators:**

- Number of training sessions and agencies completing training at each level.
- Number of training sessions and number of State Operated Hospitals and affiliated Community Mental Health Centers who complete training at each level.

**Evidence Based Supported Employment (EBSE)**

Supported Employment is an evidence-based practice that has been shown to improve employment rates of persons with serious mental illness by as much as 60%. Two grants have assisted in implementing this model in Illinois: a NIH/SAMHSA Planning grant to address state infrastructure issues (which ended in September, 2007) and a Johnson & Johnson/Dartmouth Community Mental Health Program Grant to support implementation at four pilot sites. DMH will be entering the final year of the Johnson & Johnson/Dartmouth grant in FY2009. The DMH and the DHS/Division of Rehabilitation Services (DRS) are actively collaborating to implement this evidence-based practice initiative.

In the past year the number of EBSE sites increased from 11 to 13. Four of these sites were established as a direct result of work within the NIH/SAMHSA and Johnson and Johnson/Dartmouth Grants. In FY2006 (and continuing), six sites were established using Mental Health Block Grant funding to fund six employment specialist positions on six established Assertive community Treatment (ACT) teams. The eleventh site is a community mental health agency that was an early adopter of EBSE. Two new sites have been added with the expansion of the DMH EBSE technical assistance team.

From September 1, 2006 to June 30, 2007, 1,096 individuals were enrolled in the program and received EBSE services. During the first six months, 32% of the enrollees worked in a competitive job and accumulated over 17,000 days of employment. With an additional 187 enrollees in the following quarter, persons enrolled in EBSE held a competitive job for 19,159 days between April 1 and June 30, 2007. Accomplishments in FY2008 include:

- Four new pilot sites were established after consensus was reached within the agencies to implement EBSE.
- The piloting of a financing plan was completed in FY2008. DRS and DMH reached agreement on how to blend funding to support full implementation and reward milestone outcomes. Service and billing codes related to EBSE have been

incorporated in the DMH service taxonomy. EBSE fidelity criteria have also been included in the FY2008 pilot agency contracts.

- The statewide EBSE steering committee, with large consumer and family member representation as well as a range of other stakeholders, continues to meet regularly.
- A technical assistance model for EBSE was developed and work is continuing on refining the model. Learning is ongoing in identifying technical assistance needs and strategies to guide mental health agencies and their local DRS offices on how to implement EBSE. Varying levels of technical assistance are being provided to the 11 pilot agencies.
- One fourth of the members of the technical assistance/fidelity team are persons who have lived with the experience of serious mental illness.
- The number of persons trained to provide technical assistance to EBSE providers increased from 7 to 13.
- Illinois is partnering with the Dartmouth Psychiatric Research Center to develop a Vocational Rehabilitation Fidelity Scale for EBSE to clarify the Vocational Rehabilitation role in implementing the model and increase accountability.
- Six agencies originally funded to implement EBSE on an ACT team have elected to expand their EBSE service to make it available persons receiving other mental health services at their agency.

**Objective A1.6: Continue to expand the implementation of Evidence Based Supportive Employment.**

**Indicators:**

- Number of consumers receiving supported employment who are employed in competitive jobs in FY2009.
- Number of technical assistance sessions provided to the 13 pilot sites to increase fidelity to the SE model.

**Assertive Community Treatment**

Illinois was an early adopter of the ACT model beginning implementation in 1992. ACT is the most intensive specialized model of case management in which a team of mental health professionals takes responsibility for a small group of program participants' day-to-day living and treatment needs. These individuals typically require assertive outreach and support to remain connected with the necessary mental health services to maintain their stability in the community. Often these consumers have a history of repeated admission to psychiatric inpatient or excessive use of emergency services. Previous efforts to provide linkage to necessary services have failed and the need for multiple services requires extensive coordination. The active participation of nurses, psychiatrists, and specialists trained in substance abuse is crucial to the success of the ACT model.

During FY 2007, the Illinois ACT model was modified as part of the State Medicaid Plan amendment to bring it into line with the National ACT Model and a plan was developed to monitor the fidelity of ACT services. Agencies are determining if they have the capacity to deliver the evidence-based ACT model or adopt the step-down model of the Community Support Team (CST). During FY 2008, DMH provided additional technical

assistance to agencies that elect to provide ACT services to help them to make the transition in meeting the National ACT fidelity requirements.

**Objective A1.7. Continue provision of Assertive Community Treatment that meets national fidelity model requirements.**

**Indicators:**

- Number of ACT teams meeting National fidelity standards by the end of FY 2009.

**Family Psychoeducation**

Family Psychoeducation has thrived in DMH Region I as it has been able to sustain its planning committee. This committee evolved into a public/private Family Psychoeducation (FP) implementation group. The activities of this group have resulted in the formation of a number of family psychoeducation programs. Currently, three agencies in the region are implementing one of the evidence-based models of family psychoeducation. Several other agencies developed programs in conjunction with these implementation teams. All of them have reported it as a positive experience and have cited the benefits to consumers as a result of family involvement. Staff members from community agencies, along with DMH Region I and central office staff members, continue to meet and provide mutual consultation on clinical, financial, and implementation issues, and to report on progress in individual program growth. Collaborative efforts to implement Family Psychoeducation in Illinois have resulted in an increased number of providers who have adjusted their treatment focus to extend services to more families when doing so would clearly benefit the consumer. Agencies that have been involved but have not yet implemented an EBP model of family psychoeducation have made decisions to become more family focused, and to try to rectify some of the barriers that have existed in mental health systems to involvement of families. Similarly, productive relationships between some agencies and advocacy groups such as NAMI, who has long been a participant in this project, have emerged. While the Illinois Medicaid Rule (132 ) now allows agencies to bill for family psychoeducation services in a variety of ways, a specific billing code allowing an enhanced rate has been discussed, but not as yet established. As providers understand that the practice is consistent with the new DMH and Medicaid funding; and as DMH identifies the resources for training, assisting, and monitoring providers' fidelity to the FP model, greater expansion and stability of FP is anticipated.

The objective for FY2009 will focus on continuing current planning and implementation efforts with special attention to increasing family involvement in agencies. Reducing the perceived barriers to family involvement in agencies is important to expanding the practice of the Family Psychoeducation model in Region I and eventually introducing it in other regions in the state.

**Objective A1.8. Assess the planning and implementation capacity of DMH to assist providers to consistently implement Family Psychoeducation as an evidence-based practice.**

## **Indicators**

- A report on the implementation efforts, status and capacity including progress toward the establishment of a specific billing code for Family Psychoeducation as an Evidence Based Practice in FY 2009
- Number of provider agencies in Region I taking significant steps to involve families of consumers and reduce existing barriers to family involvement by the end of FY 2009

## **Illness Management and Recovery (IMR)**

DMH staff are also engaged in active planning to begin implementation of IMR within the state.

## **DMH Public Awareness Campaign**

The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve". One way in which to address this issue is to implement strategies geared toward reducing the stigma associated with mental illness. During FY 2007, the Division of Mental Health allocated \$200,000 to implement a public awareness campaign targeting adults. This funding and activities have continued into FY2008. The DMH is developing public service brochures, and T-shirts, buttons, and a variety of other items that carry the anti-stigma message and DMH phone and web contact information to access services. The Division also distributes materials developed and supported by SAMHSA for the national "What a Difference a Friend Makes" anti-stigma campaign. A public relations firm was contracted to assist in the development of the campaign, oversee public service announcements and utilize opportunities to distribute public awareness information at large public entertainment events and through mass media outlets. The Department of Human Services is also expanding exposure of the public awareness message by insuring that the materials are distributed at the conferences and other public activities that are sponsored by other DHS Divisions.

During FY2008 campaign themes were discussed by the campaign's executive steering committee and at 6 statewide (regional) stakeholder meetings attended by over 175 participants including consumers, family members, community providers, and other stakeholders. The contractor conducted 13 distinct focus groups (with an average of six consumers in each group) carefully selected to represent Illinois' demographic profile to develop the campaign and optimize the campaign's message and long-term effect while ensuring its positive impact with respect to cultural diversity and communities throughout the state. The campaign was developed through research, testing and analysis of various approaches by mental health professionals and focus groups for reaching and appropriately responding to common perceptions of the general population as well as creating opportunities for integrating already existing family and local community resources to assist those coping with diagnosable mental health challenges. This extensive deliberation resulted in the "**Say It Out Loud**" Campaign that is more fully

described in Section I. The campaign was officially launched on May 1, 2008 at Navy Pier, one of Chicago's premier venues. The ceremony was attended by over 400 persons and received broad media coverage. It was followed by similar events in Springfield, Illinois' capital, and Peoria both among the top ten largest population centers outside of the Chicago metropolitan area.

Two major directions for the campaign are under consideration: First, the campaign could be targeted to a broad cross section of 'experts' or 'influencers' (providers) who are in a position to assist consumers and families and provide them with greater information about up-to-date treatment regimens; screening mechanisms for early identification of persons at risk of developing mental illnesses, and listing available resources with instructions for making referrals to mental health service providers. Second, inclusion of the interaction between mental health and violence prevention to positively impact persons affected by mental illnesses and violence by fostering principles of recovery and resiliency.

**Objective A1.9:** Continue to advance the public awareness campaign to reduce negative portrayals associated with mental illnesses. Expand the focus to greater access to mental health services and the interaction of mental health, the experience of violence, and applicable prevention/intervention efforts.

**Indicators:**

- Number of focus groups or expert panels conducted by contractor to obtain information to evaluate and expand the campaign.
- Materials developed for dissemination that address resource and access issues.
- Materials developed for dissemination addressing the interaction of mental health, mental illness, and violence.
- A report of the key achievements of the campaign and the significant public venues utilized to bring the message to all the citizens of Illinois.

**Forensic Services and Mental Health and Justice Activities (Adult)**

Forensic Services oversees and coordinates all forensic mental health services for the Department of Human Services - Division of Mental Health. A primary responsibility of Forensic Services is coordinating the inpatient and outpatient placements of adults and juveniles remanded by Illinois County Courts to the Department of Human Services under Statutes finding them Unfit to Stand Trial (UST) (725 ILCS, 104 -16) and Not Guilty by Reason of Insanity (NGRI) (730 ILCS, 5/5-2-4). The DMH has also implemented a number of initiatives related to the criminal justice system with key stakeholders in order to address concerns regarding the large number of non-mandated individuals with mental health needs who are involved with the criminal justice system.

**Current Activities**

**Transformation Transfer Initiative:** In FY08 DMH was awarded a SAMHSA Transformation Transfer Initiative grant for \$105,000. The grant is funding a statewide mental health/criminal justice needs assessment and system mapping initiative that will help inform the system transformation process in Illinois. The overriding goal of this initiative is to support the efforts of the Division of Mental Health (DMH) led Criminal Justice Transformation Workgroup that has been convened to recommend enhancements in the system of care for individuals with mental illness and co-occurring mental health and substance abuse disorders who are involved with the criminal justice system. A Kick-Off meeting, facilitated by the DMH Deputy Director of Forensic Services and consultants from Policy Research Associates (TAPA Center) was held with an advisory group of stakeholders from across Illinois in April of 2008. Noteworthy was the involvement of judiciary from across the state in the planning start-up. Regional planning meetings will be completed by September 2008. Results from the mapping and planning efforts will include five regional reports and an overall statewide report that will provide information on the following areas: 1) Identification of the systems that are impacted by individuals with mental illness and co-morbid substance use problems (ie, jails, prisons, shelter providers, outpatient providers), 2) Description of the intercept points where services can best be delivered to support the recovery of individuals with mental illness and co-morbid substance use problems, 3) Identification of best practices that address the needs of individuals with mental illness and co-morbid substance use problems, and, 4) Identification of gaps in service and barriers to service delivery.

**Objective A1.10: Complete a statewide needs assessment and system mapping initiative for individuals with mental illness or co-occurring mental health and substance abuse disorders who are involved with the criminal justice system.**

**Indicators:**

- Number of cross-system planning meetings convened with key stakeholders at regional and state levels.
- A final statewide report and regional reports with recommendations for enhancement and transformation of the system of care to better serve consumers with a combination of mental health, substance abuse, and criminal justice issues is drafted and disseminated.

**DMH Jail Linkage Project:** The Jail Linkage Project is a data integration initiative that collects and compares county jail intake information with DMH mental health client registration. Phase 1 began in June 1999 with funding from a federal Technology Opportunity Program (TOPS). The DMH and the Cook County Department of Corrections collaborated to link Cook County Jail detainee records with DMH community mental health client treatment records (ROCS). State legislation and special data sharing agreements made the web-based database, which contained both DMH mental health and criminal justice information, possible. The resulting files, made available daily to county jail and community mental health agency staff, are used as a supplement to the efforts directed towards identifying new detainees who need special

mental health attention and as a means through which an offender's treatment needs are updated. As a result of this project, improved discharge planning has occurred for detainees from the entire Cook County area, and made it more likely that detainees will successfully transition to the community and follow-up mental health services. Although the TOPS grant ended in October 2004, upgrades to the Cook County database have been made and data sharing agreements remain in force.

The current phase of the Jail Data Linkage Project, funded by the Federal Anti-Drug Abuse Act and administered by the Illinois Criminal Justice Information Authority, began in FY 2006 with funding of \$374,000 and is now being implemented in three counties. In contrast to Phase 1, dedicated case managers have been hired under contract to community mental health agencies, so that better coordinated services can be provided and the web-based database has been significantly upgraded. During FY 2008, 559 individuals with open DMH cases were identified in county jails through the Data Linkage Projects in Cook- Proviso, Jefferson, Marion, Peoria, and Will counties. 531 of those identified were linked to community services. Of those linked, 201 were confirmed to have kept an appointment within 1 to 30 days. FY2008 data collection has demonstrated a need for additional follow-up procedures to insure an accurate measurement of the referral and linkage of jail inmates to services. The referral process was voluntary for inmates and DMH relied on CMHCs to maintain systems for reporting when referred jail inmates sought out services. The Jail Data Link Project continues to be a primary DMH initiative for linking adults in Illinois' county jails with SMI to mental health services. Expansion to additional counties and improved reporting will be a goal for FY 2009 and the FY 2009 dataset will be used as the baseline for measuring future progress.

In FY2008, Illinois Criminal Justice Information Authority in behalf of DMH submitted a grant application to the US Department of Justice, Bureau of Justice Assistance for \$200,000 in funding for Jail Data Link expansion. If received, these funds will support initiation of a third phase that will be used to expand the Data Link Project to Madison and St. Clair counties in Region 5.

**Mental Health Court Initiatives:** As of FY2008, nine Illinois Mental Health Courts have been established that work with DMH funded agencies in their local areas: Cook, Cook-Proviso, DuPage, Kane, Lake, Madison, McHenry, Rock Island, and Winnebago Counties. A major statewide conference on mental health courts was co-sponsored by DMH with the Dupage County Health Department. In addition throughout 2008 DMH leadership staff have participated in planning meetings with other counties interested in developing Mental Health Courts.

As grant Project Director, DMH is directly involved in expanding the Cook County Mental Health Court through a Jail Diversion Targeted Expansion Grant funded by SAMHSA. The award for jail diversion targets between 185 to 265 consumers over three years (2006 - 2008) at \$399,000 annually. During FY 2008, 62 new referrals were made and there were 43 new admissions to the Cook County Mental Health Court Program. Since the inception of the grant 259 consumers have been referred and 150 consumers have participated in the Cook County Mental Health Court program. This Jail diversion

initiative, entitled The Community Re-Integration Collaborative (CRC), includes a partnership with two community providers (Thresholds and TASC), the Chicago Police Department, and the University of Illinois (program evaluator). The objectives of CRC continue to be: (1) to support community based mental health services for individuals who have a mental illness or co-occurring disorder who are diverted from the criminal justice system; (2) assure that jail diversion programs are based on best practices; (3) form and support interagency collaboration between the appropriate criminal justice, mental health and substance abuse systems; and (4) engage in policy analysis and developmental activities at a local level to promote implementation and sustenance of diversion activities. The CRC initiative included the training of 450 new CIT officers to provide street level crisis intervention and diversion of individuals with mental illness from possible arrest to the mental health system. CIT officers also coordinate with mental health service staff and assist with locating consumers participating in the Cook County Mental Health Court.

In FY2008, DMH and DASA submitted a joint CSAT grant application to SAMHSA for \$300,000 in funding to support expansion of mental health and substance abuse treatment services, and substance abuse treatment beds for Cook County Mental Health Court consumers. The grant application is under review.

**Collaboration with the Illinois Sheriffs Association (ISA):** DMH continues to take an active role in collaborating with the Illinois Sheriffs' Association to work on areas of mutual concern identified through surveys and discussion with Association members. The ISA president is participating on the Mental Health and Justice Transformation Transfer Initiative advisory group.

The following objectives are being continued from FY 2008 and will be maintained in FY09.

#### **Community Monitoring of Conditionally Released NGRI Consumers**

During FY'08: A total of 108 individual NGRI were maintained in the community on Conditional Release (CR) status. Sixteen persons were adjudicated as NGRI and released and maintained in the community during the year. At the same time, 32 were removed from the tracking system for various reasons. There are currently a total of 76 "active files" maintained in the tracking system. Agency compliance with court reporting and service delivery requirements for this population has been 100%.

#### **Objective A1.11. Maintain the tracking system for persons adjudicated Not Guilty by Reason of Insanity (NGRI) who have been released to the community.**

##### **Indicator:**

- Number of persons adjudicated as NGRI who have been released and maintained in the community**

#### **Jail Linkage Evaluation**

During FY2008, an evaluation of the Data Link Phase II initiative by Illinois Criminal Justice Information Authority is being implemented. Cook County Jail linkage continues

to need dedicated case managers. Will, Peoria, Jefferson, Mario County, and Cook-Proviso are continuing to link individuals into community services. Cook County CRC will sustain services with reduced emphasis on the use of ACT services and increased use of Community Support Team services. Grant expectations for FY2008 have been largely met with the training of 450 CIT officers and 43 consumers added to Cook County Mental Health Court.

**Objective A1.12: Evaluate linkage services for individuals with serious mental illness released from Illinois jails and the outcome goals of the implementation stage of the CRC grant initiative.**

**Indicators:**

- Complete an evaluation of the performance and outcome goals of the Data-Link Phase II initiative.
- Assess the success of efforts to sustain mental health linkage and jail diversion initiatives in Illinois.
- Assess the outcome goals of the third year of the CRC grant initiative.

**Follow-Up Community Monitoring of Unfit to Stand Trial Court Returns**

Forensic services tracks individuals discharged from DMH hospitals after inpatient fitness restoration services. A total of 372 discharged UST patients were linked to community services in FY 2007. The documented number of discharged UST patients that followed through with appointments in community agencies within thirty days of release from jail custody is 156. To date in FY2008, 351 discharged UST patients received linkage referrals and 184 discharged UST patients followed through with appointments as confirmed by providers.

**Objective 1.13: Provide continuity of care for individuals found unfit to stand trial (UST) that are restored to fitness in state operated inpatient forensic programs.**

**Indicators:**

- Number of discharged UST patients linked to community services.
- Number of discharged UST patients that follow-through with appointments in community agencies within thirty days of release from jail custody.

**Monitoring Length of Stay**

Benchmarking is being developed in FY2009 to collect data on the indicators in the following objective:

**Objective A1.14: Reduce the length of stay from the time that court orders are received to the discharge of patients referred to DHS/DMH under UST statutes.**

**Indicators:**

- The period of time between DHS receipt of court orders to placement of patients in forensic inpatient programs.
- The period of time from inpatient admission to recommendation for a court hearing based on resolution of fitness issues.
- The period of time between recommendation for a court hearing and discharge from the inpatient program.

### **Outpatient Fitness Restoration Service Monitoring and Expansion.**

Currently, DHS provides fitness restoration services on an inpatient and outpatient basis. These services are focused on providing treatment that will allow individuals found unfit to stand trial to be restored to fitness and complete their trial process. The service involves psycho-educational and clinical treatments that will assist a person in understanding the legal process of their trial and/or working with their attorney. One goal is to increase the amount of these services in least restrictive community settings and monitor the performance of outpatient providers that agree to provide fitness restoration services. In FY2008, 102 adult persons and 70 juveniles received outpatient fitness restoration services. There were 72 new referrals during the year. Agency compliance with court reporting has been at 96% and agency compliance with providing fitness restoration services has been at 100%. This objective is continuing in FY2009.

#### **Objective A1.15. Develop and maintain a tracking system for persons receiving outpatient fitness restoration services.**

##### **Indicators:**

- Number of adult persons receiving outpatient fitness restoration services in FY2009.
- Number of juveniles receiving outpatient fitness restoration services in FY2009.
- Number of new cases referred for outpatient fitness restoration in FY2009.
- Agency compliance with court reporting in FY2009.
- Agency compliance with providing fitness restoration services for UST patients in FY2009.

#### **Services for Individuals with Co-occurring Mental Illnesses and Substance Abuse Disorders**

Addressing the treatment needs of individuals with co-occurring disorders requires the collaboration of mental health and substance abuse agencies at the state and local levels. The Division of Mental Health (DMH) and the Division of Alcohol and Substance Abuse (DASA) have worked diligently over the years to collaborate, develop and implement initiatives focusing on consumers with co-occurring disorders. These collaborations include co-location projects that continued through FY 2008 at four state hospitals; Elgin, Chicago Read, Madden, and McFarland. Sharing service delivery site resources allows DASA funded providers to perform screening and assessment for consumers on-site, and provide consultation to DMH staff regarding the substance abuse treatment needs of consumers when these services are warranted. Sharing facilities has resulted in the development of more hospital staff training and expanded the role of the DASA providers to perform linkage and engagement activities. DMH has initiated data collection on service timelines, major diagnosis and interventions by co-location service providers.

**Objective A1.16.** Jointly with the DHS Division of Alcoholism and Substance Abuse (DASA), continue to collaborate on planning services delivered to individuals with co-occurring disorders.

**Indicators:**

- Number of meetings between DMH and DASA staff

**Objectives Related To National Outcome Measure Performance Indicators**

The following objectives relate to the SAMHSA CMHS National Outcome Measures (NOMS):

**Objective A1.17 (NOM):** Continue efforts to increase the implementation of Evidence Based Practices.

**Indicator:**

- Number of EBPs implemented.
- Number of individuals receiving each EBP.

As described above, the DMH has made significant progress in efforts to implement evidence-based practices in FY2008. These efforts will continue in FY2009.

**Objective A1.18 (NOM):** Continue efforts to decrease 30 day and 180 day readmission rates to DMH state hospitals.

**Indicators:**

- Percentage of adults readmitted to state hospitals within 30 days of being discharged
- Percentage of adults readmitted to state hospitals with 180 days of being discharged.

The DMH continues efforts to decrease 30 day and 180 day readmission rates to DMH state hospitals. There was a decrease in 30-day readmission rates from FY2005 (12.7%) to FY2006 (11.4%). There was a slight decrease across the same time period for 180-day readmission rates (12.7% vs. 12% respectively). (Note: Data is not yet available for FY 2008)

**Objective A1.19 (NOM):** The percentage of consumers reporting positive outcome will increase in FY 2009 (See State Capacity Checklist in Appendix 2.)

**Indicator:**

- Percentage of consumers reporting positively about outcomes

(Note: Consumer Access to Care is reported under Criterion 2 as a quantitative performance measure.)

**Additional Illinois Specific System Performance Indicators**

The DMH has established the National Outcome Measures (as displayed above) along with additional system indicators to track mental health system service delivery and to aid in service planning. Each indicator is described in detail in Section III-B.

Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2005 through FY2007, and projections have been made for FY 2008 and FY2009. FY 2008 actual data will be provided in the FY2008 Mental Health Block Grant Implementation Report.

<b>Key System Performance Indicators – ADULT SERVICES</b>		
<b>Indicator Number</b>	<b>Reference</b>	<b>Indicator Description</b>
<b>Criterion 1</b>		
A1.1A (NOM)	Number of EBPs offered	
A1.1B	Percent of individuals receiving each EBP	
A1.2 (NOM)	Decrease Rate of civil readmission to state psychiatric hospitals within thirty days of being discharged from a state hospital.	
A1.3 (NOM)	Decrease Rate of civil readmission to state psychiatric hospitals within 180 days of being discharged from a state hospital	
A1.4	Percentage of adults engaged in full or part-time competitive employment	
A1.5	Percentage of adults engaged in full or part-time employment in subsidized, supported or sheltered employment	
A1.6	Percentage of adults living independently in the community	
A1.7	Percentage of adults court ordered into outpatient treatment	
A1.8	Percentage of adults reporting involvement with the criminal justice system (Department of Corrections)	
A1.9	Percentage of adults with co-occurring mental illness and substance abuse disorders receiving service	
A1.10	Percentage of ACT service hours provided in community settings	
A1.11	Percentage of adults with diagnoses of 295 or 296 receiving case management services	
A.1.12 (NOM)*	Percentage of adults reporting positively about outcomes	
A.1.13 (NOM) *	Percent of adult clients who are competitively employed	
A.1.14 (NOM)*	Percent of clients arrested in year 1 who were not rearrested in year 2	

A1.15 (NOM)*	Percent of adult clients who were homeless or living in a shelter
A1.16 (NOM)*	Percent of clients reporting positively about Social Supports/Social connectedness
A1.17 (NOM)*	Percent of clients reporting positively about Social Supports/Social connectedness Improved Level of Functioning
<b><i>Total Number of Adult System Indicators</i></b>	<b><i>17</i></b>

# Illinois

## Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;  
Employment services;  
Housing services;  
Educational services;  
Substance abuse services;  
Medical and dental services;  
Support services;  
Services provided by local school systems under the Individuals with Disabilities Education Act;  
Case management services;  
Services for persons with co-occurring (substance abuse/mental health) disorders; and  
Other activities leading to reduction of hospitalization.

See Section II. Adults - Available Services and Strengths

# Illinois

## Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

#### Prevalence Estimate

The CMHS definition and methodology for prevalence estimation for adults is published in final notice form in the Federal Register Volume 64, Number 121, June 24, 1999. The methodology provides a calibrated point estimate of the 12 month number of persons who have Serious Mental Illness, age 18 and older in Illinois. This does not include persons who are homeless and institutionalized. The prevalence estimate provided by CMHS is 5.4%. Based on the adult population for Illinois, it is estimated that in FY2008 there were 519,421 adults with serious mental illnesses residing in Illinois.

# Illinois

## Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

## **Criterion 2: Mental Health System Data Epidemiology**

### **Quantitative Targets For FY2009**

The DMH wishes assure that mental health services are accessible to individuals needing these services. Therefore DMH will continue to work toward increasing access to services.

Performance Indicator (NOMS) A.2.0 Number of adults served by Age

Performance Indicator (NOMS) A2.1 Number of adults served by gender

Performance Indicators (NOMS) A.2.3 Number of adults served by race/ethnicity

The DMH continues efforts to increase access to services by adults with serious mental illnesses as measured using DMH criteria. In FY 2005, 56.5% of adults receiving services met DMH criteria and in FY 2006 it was 56.6%. In FY2007, it remained steady at 56.5%. (Note: Data for FY2008 will be provided in the implementation report.) The goal of increasing the percentage to over 57% will be pursued in FY2009.

### **Performance Indicator A2.4 Increased Access to Services by the DMH Target Population**

#### **Indicator:**

- Percentage of the DMH adult target population receiving services

The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY 2005, 94.8% of adults receiving services met the eligible population criteria, while in FY 2006, the percentage was 94.2%. In FY2007, 132,787 adults met the criteria for eligible population accounting for 93.6% of all adults served. Although the percentage dropped, the actual number of adults in this population increased by 10,758 persons in one year.. (Note: Data for FY2008 will be provided in the implementation report.) We will continue to focus on this indicator in FY2009.

### **Performance Indicator A2.5 Increased Access to Services by the DMH Eligible Population.**

#### **Indicator:**

- Percentage of the DMH adult Eligible Population receiving services

### **System Performance Indicators**

Each indicator for Criterion II (see Table below) is described in Section III-B. Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2005 through FY 2007, and projections have been made for FY 2008and FY 2009. FY 2008 actual data will be provided in the FY 2008 Mental Health Block Grant Implementation Report.

<b>Criterion 2</b>	
A2.0-2.3 (NOM)*	Number Of Adults Served. Continue breakdown by Gender,(A2.1), Race/Ethnicity, (A2.2), and Age (2.3).
A2.4	Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
A2.5	Percent of individuals being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.

# Illinois

## Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

## **The Homeless Population in Illinois**

### **Emergency Food and Shelter (EF&S) Services Annual Report**

The most reliable source, though not complete, for descriptive data of the homeless population is the IDHS Division of Human Capitol Development, Office of Family Support Services, which administers the Emergency Food and Shelter (EF&S) program. This program was developed to provide immediate food and shelter to homeless persons and families or to persons and families at imminent risk of becoming homeless. It provides meals, beds and supportive services through not-for-profit organizations to homeless individuals and families to assist them to return to self-sufficiency. The General Revenue Fund (GRF) allocation for the EF&S Program in FY2007 totaled approximately \$8.5 million. Between July 1, 2006 and June 30, 2007 there were 47,697 individuals that received shelter, food, and services to meet their emergency needs and help them regain self-sufficiency. During the year, organizations funded through the EF&S Program provided 2,078,867 nights of shelter, served 2,963,275 meals and delivered 2,474,881 units of supportive services. See Section II for a summary of EF&S services and the FY2007 Report.

## **Outreach and Services to Homeless Adults**

See Section II, this criterion, for a summary.

## **Number of Homeless Persons Receiving Services**

**System Performance Indicator A4.1** was created in FY 1999 to track the number of homeless adults entering community-based services funded by public mental health dollars. This indicator permits an initial evaluation of the ability to provide access to mental health services for those individuals who are homeless and have mental illnesses. DMH plans to maintain or expand access to community mental health services by persons with mental illness who are homeless. In FY 2007, there were 7,639 homeless adults receiving DMH funded services which represents a substantial increase (15%) over the number of persons accessing service in FY 2006.

## **Project for Assistance in Transition from Homelessness (PATH)**

The State of Illinois has an extensive history of working with individuals and families who are experiencing homelessness. Since 1988, Illinois has been a recipient of federal funds provided by the Stewart B. McKinney Act, which was enacted into legislation to address the crisis of homelessness among the nation's population of individuals who are homeless or at imminent risk of homelessness with a serious mental illness who may have a co-occurring substance abuse disorder. In 1991, this Block Grant evolved into a federal formula funding award titled Projects for Assistance in Transition from Homelessness (PATH). The funds are governed by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS). Illinois providers have developed an array of services that include in vivo case management, crisis intervention services, a day center/drop-in-program, and two (2) mobile assessment units in the City of Chicago.

Allocations for the PATH program have fluctuated in recent years, and providers have diligently continued to use funds to expand and enhance services to homeless persons with mental illness. In FY 2006, the funding increased from \$2,192,000 to \$2,441,000. In FY 2007, funds decreased from \$2,441,000 to \$2,414,000, and in FY 2008, funds decreased from \$2,414,000 to \$2,366,000-a loss of \$49,000- which was reconciled by a pro-rated percentage per provider.

In FY 2008, the Illinois PATH Program's transitional-residential program was closed at the Provider's request, due to Match Dollar issues - which resulted in the following restructure of \$236,000 in funds within the same geographic community:

- Two (2) new agencies were added to the Illinois PATH Providers' roster,
- There were adjustments in allocations and increases in the case management services of two current providers, and
- 8.0 FTE staff were hired to serve an estimated additional 185 individuals who met PATH-eligible criteria. (two (2) .5 FTE's are Consumers)

The increase in case management is being targeted to homeless persons with mental illnesses being released from jail. Currently, all PATH funding is used for the provision of case management services with the exception of \$53,000 for a drop-in center (Rockford) and \$653,000 in two Mobile Assessment Units (Chicago) operated by Thresholds - which do in vivo outreach and engagement. In Federal FY2006 (October 1, 2005 through September 30, 2006), 1,681 persons who met PATH eligibility were served with PATH funds. The targeted number of PATH eligible consumers served in FY2007 was estimated at 1,866. PATH providers have projected a substantive increase in the number served next year that is based upon new procedural efficiencies and the expansion of available resources through increased community collaboration. The targeted number of PATH eligible consumers to be served in FY2009 is 2,090.

The PATH program continues to work on hiring consumers as staff in PATH-funded agencies. Two additional consumers will be hired statewide in FY2009.

**Objective A4.1: By the end of FY2009, target case management services to 200 more PATH eligible consumers than were served in FY2008.**

**Indicators:**

- Number of persons receiving case management services under the PATH initiative by the end of FY2009.
- Number of persons identified as eligible for enrollment and receiving PATH services by the end of FY 2009 will show an increase of 10% over the total number of persons served in FY 2008.

Illinois will hold its first PATH Providers Conference in Bloomington September 18-19, 2008. The Conference Planning Committee is comprised of nine (9) PATH Provider organizations and the State PATH Coordinator. The objectives of this Conference include training in innovative strategies, opportunities for cross-system

sharing of ideas and strategies, and developing a broader network which will be beneficial to consumers. The following learning experiences have been targeted for the conference: (a) access to advances in MISA Services and affective recognition of co-occurring disorders, (b) how to identify and address challenges that may arise when working with individuals who have a history of incarceration, (c) successful strategies to employ when providing diagnostic training to staff without clinical backgrounds, (d) effective techniques of outreach and engagement to PATH-eligible individuals in Chicago communities, (e) federal-level recovery and wellness methods for homeless services teams and consumers, (f) the benefits of psychopharmacology and the possible outcomes/effects on the consumers receiving services, (g) challenges and successes experienced of the Presumptive Eligibility Pilot Project: (Social Security Benefits for Homeless Individuals). The conference will emphasize the participation of PATH-enrolled consumers by supporting their attendance.

**Objective A4.2: In FY2009, convene the 1st Annual PATH Provider's Conference: "PATH: Bridging the Gap Between Mental Illness and Homelessness".**

**Indicators:**

- **Number of attendees at the Conference who represent mental health and homeless interests outside the PATH service system.**
- **Number of PATH Providers in attendance.**
- **Number of Consumers in attendance.**
- **Number of Evaluation forms completed.**
- **Number of Conference Evaluations showing successful scores.**

**DMH and Continuums of Care**

The U.S. Department of Housing and Urban Development (HUD) initiated the Continuum of Care process in 1994 to encourage a coordinated, strategic approach to planning for programs that assist homeless individuals and families. To apply for federal funding, jurisdictions must submit a continuum of care plan that demonstrates the broad participation of community stakeholders and that identifies the resources and gaps in the community's approach to providing a range of homeless services. Community stakeholders determine local priorities for funding. The fundamental components of a comprehensive Continuum of Care system are:

- Outreach, intake, and assessment to identify the individual's or family's service and housing needs and link them to appropriate housing /service resources.
- Emergency shelters and safe, decent alternatives to living on the streets.
- Transitional housing with supportive services to help people develop the skills necessary to permanent housing.
- Permanent housing and permanent supportive housing.

Continuum of care planning helps communities to assess capacity and identify service gaps, be proactive in responding to policy and demographic changes rather than reactive, develop common goals, improves the coordination and linking of resources, promotes community "buy-in" and access to mainstream resources, and makes communities highly competitive for McKinney Homeless Assistance funding.

The DMH is represented on Continuums of Care boards statewide through its Comprehensive Community Service Regions (CCSRs), and its funded CMHCs who are members. In the Chicago area, the DMH is a member of the Alliance to End Homelessness in Suburban Cook County and is represented on the Chicago Planning Council on Homelessness. As a large percentage of homeless persons in the Chicago area have a diagnosable mental health condition, HUD funding is vital to support the provision of mental health services and the development of permanent supportive housing. In suburban Cook County, HUD funds support Project WIN(Wellness Initiative Network) which is a multi-agency, multi-service collaboration to provide coordinated care in the areas of mental health, medical health, and substance abuse treatment. To engage homeless persons in these critical services, a team of clinicians provide on-site assessments and linkage to mental health services at the emergency shelters. Significant progress is reported in the collaboration between homeless service providers and mental health service providers. In Greater Illinois, PATH funded mental health providers are actively involved in Continuums of Care located across the State. Examples are: the Delta Center, Inc in Cairo, at the southern tip of Illinois, is a member of the Southern Illinois Continuum of Care; staff of the CMHC of St. Clair County in East St. Louis have served on the Homeless Action Coalition in St. Clair County; and the Janet Wattles Center in Rockford (northwestern Illinois) is part of the HUD Continuum of Care program under the auspices of the Winnebago/Boone Counties Mayors' Task Force on Homelessness which has been in existence in Rockford since 1988 and Janet Wattles Center was a founding member.

# Illinois

## Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

## **Adult Services In Rural Areas**

### **Providing Mental Health Services to Residents of Rural Areas.**

DMH continues to track the number of residents residing in rural areas that receive DMH funded services (**see System Performance Indicator A4.2**). Seventy-six counties have been identified as rural in Illinois with an adult population of 1,509,159 according to 2000 census figures, yielding a prevalence estimate of 81,494 (at 5.4%). In FY 1999, when this system indicator was first established, 25,127 individuals who lived in the 76 rural counties were reported as receiving services. By FY 2005, the number had increased to 28,510. By the end of FY2007, the number had increased substantially (22%) to 34,807.

The DMH Southern Region, whose service area is primarily rural, has previously conducted an analysis of the service needs of consumers within its geographic area to identify what resources are needed to reach the goal of having appropriate service provision available within a 25-mile radius of a consumer's home. Data gathered through this analysis permitted DMH Regional staff to strategically fund new services consistent with defined need. Agreements were also initiated to facilitate and increase access to Psychosocial Rehabilitation programs and supported housing arrangements. Informational mapping was undertaken and developed for each of the 16 community mental health centers and the counties served by these centers which identified the estimated number of persons with serious mental illness (SMI) residing in each service area; the number of persons with SMI served by each center; the service capacity for both youth and adults; and the average expenditure for persons at 200% of poverty. This mapping has provided a clear perspective and understanding of the gap between community mental health center capacity and prevalence of persons with SMI. DMH Regional staff have also worked with the Southern Illinois Health Consortium to connect and integrate mental health services with existing federally qualified health centers (FQHCs).

### **The Stark County Rural Mental Health Initiative**

This initiative is a new and unique development to rural mental health in Illinois. It demonstrates the resolve of persons residing in sparsely populated rural areas to access the mental health services they require. The grass roots beginning of this initiative, the enthusiasm it engendered, and the regional and state support it has received reflect the nature of rural settings and are evidence of the significant system change that can occur when stakeholders with a common interest work together.

Stark County is a rural county located in north central Illinois, not far from Peoria. The total population of the county is 6,300. A triple homicide in 2002, followed in 2003 by five suicides in eight days and a sixth one later in the year, prompted several citizens to become concerned and active in looking at what could be done to prevent recurrent tragedies. Others soon joined them, and, in 2004 the Stark County Citizens Mental Health Task Force was formed with a collaboration of citizens, ministers, law enforcement, and a mental health provider. A survey of the county revealed that less than ten individuals in the county were receiving mental health and substance abuse services and that distances to providers in other counties were prohibitive. With support and assistance from the Mental Health Association of Illinois Valley, located in Peoria and the DMH Region III,

the Task Force subsequently developed a rural mental health initiative designed to provide access, education, and advocacy services to the citizens of Stark County with respect to mental health and substance abuse services. The initiative is a collaboration between the Stark County Citizens' Mental Health Task Force, DMH, and participating regional and local service providers including the Henry-Stark County Health Department, the school district, and the local office of the Illinois Violence Prevention Authority. Since FY2006, the initiative has been successful in obtaining a variety of modest grants to fund its activities. DMH issued a targeted services proposal to the CMHCs in the area and North Central Behavioral Health Services was selected. This CMHC has assigned a full time mental health clinician to the Stark county initiative. This clinician now oversees a caseload of sixty persons receiving needed mental health services in the county. The initiative has hired a full-time advocate and the school district is dedicating a .5 FTE social worker to the project.

The Stark County Rural Mental Health Initiative provides access, education, and advocacy services to the citizens of Stark County. The mission of the initiative is community-based, family-focused and recovery-oriented for persons with mental health and substance abuse problems. Access services provided by the initiative include: mental health and substance abuse screening and treatment; counseling services at school, in the home, or at the DHS Office in the county seat; an on-line community resource directory; and a crisis hotline available 24 hours a day. Educational activities include: training in suicide prevention skills; alcohol, tobacco and other drug prevention programs in local communities; promoting awareness and understanding of mental health and mental illnesses; presentations for civic groups, employers, and schools on issues related to mental health and substance abuse; and family support through the NAMI Stark County. Advocacy occurs at several levels including one-on-one advocacy to support individuals and families as they attempt to access services, collaborative work to improve communication and cut out "red tape", and interagency collaboration and planning for local and regional issues impacting behavioral health. The initiative is invested and active in supporting other counties to replicate the experience. Sustainability of the initiative is planned through local fundraising efforts such as Whitney's Walk For Life, an annual event aimed at increasing awareness of teen suicide, which began in 2004, and has so far raised over \$150,000 for increasing depression awareness and suicide prevention programs in the central Illinois area.

### **Use of Communication Technology as a Basis for Service Delivery**

In FY 2009, as resources allow, newer technology such as advanced telecommunication systems will be used to improve access to expertise from professionals located in urban areas to persons residing in rural areas. Internet access, video conferencing, and other applications provide an opportunity to enhance the quality of care in rural mental health services. These approaches also provide substantial support to model programs with new designs for better integration of mental health and primary healthcare in rural areas.

# Illinois

## Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

## **Services To Older Adults**

See Criterion 4, Section II for an overview of service issues.

The Division of Mental Health convenes an Advisory Committee on Geriatric Services jointly with the Illinois Department on Aging (DOA) which focuses on the assessment of the mental health needs of elderly persons, identifying the competencies needed to serve them and identifying model programs and best service practices. The Council also promotes increased awareness of geriatric mental health concerns and has provided training, consultation and technical assistance in the area of mental health and aging issues. The Geriatric Advisory Council developed a position paper on issues of Self-Neglect that was used widely throughout the state including a Self-Neglect Forum and the Self-Neglect Task Force. The Division of Mental Health contributes staff to participate in the Self-Neglect Task Force, and the "Aging is an Asset" project convened by the Illinois Department on Aging. The DMH also serves in an advisory capacity to the statewide, Northern and Southern Mental Health and Aging Coalition. The Division of Mental Health and the Illinois Department of Aging also collaborated with resources and expertise to develop, market and present three conferences: the Annual Statewide Mental Health and Aging Conference; the Behavioral Health, Aging and Wellness Conference; and the Rural Aging Conference. Geriatric Specialists gave presentations at the national American Society of Aging/National Coalition on Mental Health and Aging and assisted in the cross training of the Illinois Department on Aging staff regarding domains on the Comprehensive Case Management Assessment. The Illinois Department on Aging has developed a proposal to fund a statewide expansion of the Gero-Psychiatric Project through the Division of Mental Health.

## **Geropsychiatry Services**

See Section II for a description of this program.

**Objective A4.3. In collaboration with the Illinois Department On Aging (IDOA), convene meetings with stakeholders to improve access to treatment by older adults.**

**Indicator:**

- Number of meetings convened in FY 2009.

## **Performance Indicators**

**These System Performance Indicators for Criterion all of IV are presented in detail in Section III-B.**

<b>Criterion 4</b>	
A4.1	Number of individuals being served by DMH-funded community-based providers who are reported as undomiciled or homeless at the time of entry into service.
A4.2	Number of individuals being served by

	DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
--	-----------------------------------------------------------------------------------------------------------

# Illinois

## Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

The DHS Division of Mental Health continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those that are responsible for emergency health services regarding mental health.

### **Enhancing Financial Resources**

#### **Increased Financial Resources for Community Services**

As noted previously in Section II, this criterion, there has been a substantial increase in the proportion of the DMH budget spent on community mental health services across fiscal years. The DMH has undertaken a number of efforts to increase the financial resources available to support community-based mental health services in Illinois. Many of these initiatives have been discussed in Sections I and II.

#### **Increasing Financial Resources For The Adult Population**

As noted in Section II, financial resources for both the adult and children and adolescent populations come from General Revenue Funds (GRF) appropriated by the Legislature, Block Grant funds, and the redirection of dollars accrued from the reduced utilization of state hospital services and annualized income from previous initiatives.

#### **Increasing Federal Financial Participation (FFP)**

*The content of this section is the same for both the Adult and the Child Plan. Objective A5.1/C5.1 covers both adults and children. The text is presented here and referenced in the Child Plan, Section III-A, Criterion 5.*

Over the past seven years, the DMH has worked closely with community agencies on an aggressive plan to increase the claiming of Federal Medicaid funds to support community based mental health services. In FY2003, DMH was able to support efforts to increase Medicaid Funding for the Illinois Mental Health Service System by simplifying and clarifying Medicaid policies and procedures (making necessary changes in the State Medicaid Plan, 59 Ill. Admin. Rule 132, the DMH Medicaid Handbook, and the DMH Program Book). Also during FY2003, the structure for utilization of the Medicaid Trust Fund was established and implemented. The distinction and importance of this fund is that it is a federal trust fund based exclusively upon the anticipated federal revenues from Medicaid payments for community mental health services. As billing for Medicaid services increases, so do the resources in the fund. Medicaid reimbursement through the Trust Fund continues to increase across time. In FY2003 Medicaid reimbursement through the Trust Fund was \$59 million; in FY2006 it had risen to \$79,689,964. In FY2007, \$84.4 million was deposited in the Trust Fund, and \$85.4 million in deposits is anticipated for FY 2008. It is expected that there will be continuing increases in Medicaid billing as the mental health system continues to become more efficient in its billing and reporting practices. The focus on increasing Medicaid capture will continue in FY 2009.

Accomplishments to date on the continuing objective below (A.5.1) include:

- ✓ The state's Mental Health Medicaid Rule (Rule 132) was revised again during FY2008 and approved by the legislative committee for implementation on July 1, 2008 (FY 2009). These revisions clarify and enhance standards for services and

other provisions of the Rule. Additional revisions are anticipated in future years in an effort to keep the Rule as current as possible and minimize exceptionally large changes and revisions in the Rule.

- ✓ Beginning in January 2008 prior approval processes were implemented for some of the most expensive services funded by DHS/DMH, with an Administrative Services Organization (ASO) assuming operational responsibilities for these as well as the existing approval process for ACT previously performed by DMH staff. The ASO provides technology and statewide consistency making this service utilization management process efficient and effective. As more data becomes available and analyses completed, it is anticipated that additional service utilization processes will be implemented to ensure that the right consumers are receiving the right services in the right amount at the right time.
- ✓ In collaboration with the Department of Healthcare and Family Services, the state's Medicaid agency, DMH has initiated a project to automate the Medicaid "spend down" provisions for eligible individuals with serious mental illness. Implementation of this process is planned for FY 2009.
- ✓ Through the Medicaid Rule revision, DMH has improved and clarified the documentation requirements to enhance providers' and states compliance with federal and state Medicaid regulations and expectations.
- ✓ In FY2008, with legislative guidance, DMH initiated a process of more closely relating providers' payments to the amount of services actually delivered to consumers (as contrasted with the previous payment system that focused dollars actually expended, rather than services delivered). For FY 2009 providers with billing performance at the extremely high or low ends had their estimated contract amounts for FY 2009 adjusted to more closely reflect their actual level of service provision and billing. These steps toward fee-for-service will continue throughout FY 2009.
- ✓ Estimated FFP deposits for FY2008 (excluding \$3.5 million diverted to General Revenue Fund): \$85,426,176

**Objective A5.1/C5.1. Increase Medicaid funding for the Illinois mental health service system. This will be accomplished by:**

- Simplifying and clarifying DMH Medicaid policies and procedures.
- Developing and maintaining a system for utilization management within the Medicaid program.
- Identifying and eliminating internal barriers to increasing Medicaid billing and to enhancing eligibility for clients who use DMH funded mental health services (including patients in state psychiatric hospitals).
- Streamlining the documentation requirements of providers.
- Continuing implementation of fee-for-service funding.

**Indicator:**

- **Amount of FFP generated in FY 2009.**

**Medicaid Billing For The Adult Population**

Medicaid billing has risen substantially over the years. In FY2004 Medicaid billing for adults had risen to \$123,821,924, in FY 2005 it was \$129,028,640 and in FY 2006 it was \$149,599,641. Total Medicaid billing in FY2007 rose to \$164,742,868 and has been maintained in FY2008 at \$164,407,968.

# Illinois

## Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

## **Enhancing Human Resources**

Human resource development is critical in terms of supporting community-based services for adults with serious mental illness and children with serious emotional disturbance and their families.

### **Activities Related to Human Resource Development**

As noted in Section II, Illinois has a long-standing history of public and academic collaboration with Departments of Psychiatry, Social Work, Psychology, and Nursing in universities across the state. DMH also continues to support human resource development through the following activities:

- Continued funding of the Illinois Nursing Institute which addresses competencies needed by DMH psychiatric nurses.
- Providing training and consultation to community providers in the implementation of IDDT.
- Recruiting and training consumers to become Recovery Specialists.
- Establishment of the Certified Recovery Support Specialist credentialing process.
- Recruiting and training consumers as WRAP facilitators.
- Providing training and consultation to community providers around the implementation of medication algorithms with the DMH/University of Illinois Center for the Implementation of Medication Algorithms (CIMA).
- Initiatives in which psychiatric consultation is provided to community mental health providers in remote and rural areas in the state.
- Mental Health and Law Enforcement Training -The DMH regularly collaborates with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis.
- Provision of technical assistance and training to agencies to improve the efficiency of billing and agency operation.
- Provision of technical assistance and training to DMH staff regarding Fee For Service related issues.
- Training of SRI consumer liaisons so that they are prepared to provide input into SRI activities.

## **Human Resource Development Related To Adult Services**

### **Recovery Oriented Training**

Training events that assist in the implementation of the Recovery Vision in Illinois continue to be a priority of DMH. This training is offered statewide through DMH Regions and through other venues to providers, consumers, family members and other interested stakeholders. DMH Recovery Services staff members provide training on Recovery using a standardized training curriculum that was developed in FY2002. Other initiatives, such as Recovery Specialist Training, and training in the WRAP model, as described in Sections II of this application, also support these efforts.

### **The DMH Nursing Institute**

The DMH contracts with the University of Illinois in Peoria to fund the Nursing Institute. The Institute provides targeted training and develops targeted deliverables based on an annual negotiation with DMH Staff. During FY2007 the Institute completed development of a web-based application to provide training to psychiatric nurses on the competencies required to perform their job and responsibilities.

### **Disaster Response: Emergency Health Services**

As reported in Section I of this application, the Governor has designated DMH as the lead State agency for disaster resource coordination, training and recovery functions related to mental health. Working in the collaborative context of the overall Statewide Disaster Plan, DMH is coordinating Illinois' disaster preparedness for state operated and state funded psychiatric service entities. The operational focus includes collaboration and training with other State agencies, monitoring and facilitating ongoing concordance with NIMS, and assisting State funded agencies in the development of local response capability for issues of Mental Health. DMH also coordinates surge deployment of mental health services in response to disasters, be they natural or caused by terrorists. This is an ongoing effort that has been enhanced by a grant award from SAMHSA for \$200,000 for disaster response planning which began in FY2004. The first two years of development have seen the establishment of a statewide coalition dedicated to disaster response, the planning and execution of statewide training in disaster preparedness, and the establishment of an understanding with the SEOC, Safety and Disaster Response Office (a newly created office) City of Chicago, as well as the Illinois Emergency Management Authority (IEMA). Following Hurricane Katrina, the Governor of Illinois made a commitment of rather wide scope, to assist the evacuees. As DMH is the lead State agency for disaster resource coordination, training and recovery functions related to mental health, a grant application was submitted to SAMHSA for a Crisis Counseling Grant that was subsequently funded. Currently an operation for the relief of residents of Iroquois and Livingston Counties is concluding. A final report to SAMHSA is underway. Working in the context of the overall Statewide Disaster Plan, DMH coordinated the program directly. The operational focus of work included statewide outreach, collaboration with other State agencies, monitoring and daily program operation. As the state lead on mental health in disaster planning, DMH applied for, and received an Immediate Services Program (ISP) Crisis Counseling Grant to provide services to residents of those counties in the amount of \$33,802. The program allowed for the canvassing of both counties of Iroquois and Livingston and was able to make contact with 1,287 (Iroquois-771, Livingston-516) people, through either direct or indirect efforts.

### **Crisis Response at NIU**

In the wake of the shootings at Virginia Tech in April, 2007, the Governor convened the Illinois Campus Security Task Force co-chaired by the Director of the Division of Mental Health, the Attorney General of Illinois, and the Director of the Illinois Emergency Management Association, to develop a plan for campus security and trauma –related services on Illinois university campuses. The Task Group consisted of representatives from a range of state agencies, law enforcement agencies, and universities. A crisis

response plan was formulated which included the activation of crisis response teams and counseling personnel to deal with the aftermath of a traumatic sentinel event. Prevention and early intervention issues as well as the availability of mental health services to students on college campuses were also discussed. In February, 2008, a gunman shot and killed five students and injured others in a lecture hall, before shooting himself at Northern Illinois University at De Kalb. The Governor immediately ordered a state level "Call to Action" and the crisis response plan, formulated just several months earlier, was implemented. For the students present in the classroom, the general student population, parents, faculty, and personnel, post-traumatic services were immediately available. More than 300 mental health workers and counselors were on campus during a ceremonial resumption of classes a week later and remained on campus for several days to help students process the grief and trauma of the event.

# Illinois

## Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

The DHS Division of Mental Health continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those that are responsible for emergency health services regarding mental health.

### **Enhancing Financial Resources**

See Section II, Criterion 5 of the Adult Plan for a discussion of this topic which is applicable to both adults and children.

#### ***Increasing Financial Resources For The Child And Adolescent Population***

The DMH and its partners have been successful in increasing financial resources to provide/purchase services for children and adolescents and their families through several sources. For example, the System of Care Chicago grant that has brought major new funds targeting the child and adolescent population into the state. This grant, which was funded at \$9.5 million over a six year period has ended. The system of care grant awarded by SAMHSA CMHS to McHenry County in FY 2005 was also funded at \$9 million dollars per year over a six year period. The McHenry SOCC will continue through FY 2011. In FY 2008, \$6.5 million dollars has been allocated for mental health services for children and adolescents through a partnership with the Illinois Children's Mental Health Partnership.

#### ***Increasing Federal Financial Participation (FFP)***

***This section is applicable to both adults and children. It is available in the Adult Plan, Section III-A, Criterion 5. Objective A5.1/C5.1 of the Adult Plan covers adults and children.***

**Table C. MHBG Funding for Transformation Activities**  
**State: Illinois**

	Column 1 Is MHBG funding used to support this goal? If yes, please check	Column 2	
		If yes, please provide the <i>actual or estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY	
		Actual	Estimated
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	<input type="checkbox"/>		
GOAL 2: Mental Health Care is Consumer and Family Driven	<input type="checkbox"/>		
GOAL 3: Disparities in Mental Health Services are Eliminated	<input type="checkbox"/>		
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	<input type="checkbox"/>		
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	<input type="checkbox"/>		
GOAL 6: Technology Is Used to Access Mental Health Care and Information	<input type="checkbox"/>		
<b>Total MHBG Funds</b>	N/A	0	0

\*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research ... Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

# Illinois

## Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

## **SECTION III-C: TRANSFORMATION**

### **Illinois Transformation Agenda**

Since July, 2003, when the President's New Freedom Commission on Mental Health released its final report, the Division of Mental Health has focused its efforts at reforms and improvements in the Illinois public mental health system in accordance with the six principal goals of a transformed system of care which were articulated by the Commission:

- 1) Americans understand that mental health is essential to overall health. (See Criterion I)**
- 2) Mental health care is consumer and family driven. (See Criterion I)**
- 3) Disparities in mental health services are eliminated. (See Criterion 2 and Criterion 4)**
- 4) Early mental health screening, assessment, and referral to services are common practice. (See Criterion I, Criterion 3, Criterion 4, and Criterion 5.)**
- 5) Excellent mental health care is delivered and research is accelerated. See Criterion 1 and Criterion 5)**
- 6) Technology is used to access mental health care and information. (See Criterion 2 and Criterion 4.)**

The Commission's goals and recommendations were based on the key principle that public mental health systems should be altered to make recovery from mental illness the expected outcome from a transformed system of care:

**“We envision a future when everyone with a mental illness will recover, mental illnesses can be prevented or cured, mental illnesses are detected early, everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community”**

Beginning in 2003 and continuing through 2004, the Illinois Department of Human Services (DHS) convened Work Out Groups composed of DHS staff and key stakeholders to recommend actions in response to a range of perceived challenges being presented in the mental health system of care. Their primary concerns were the identification and analysis of service system gaps and planning for a continuum of care infused with evidence-based and best practices across multiple systems. .

These DHS Work Out Groups first articulated the existence of significant cross-system mental health issues and the need for comprehensive mental health planning.

A Strategic Vision Report, a product of the DMH System Restructuring Initiative (SRI), was completed in May, 2005. Based on feedback from planning retreats with state agency staffers and from more than 200 stakeholders through the use of focus groups, the report identified the need to increase DMH's leadership role (consistent with state statute) with respect to the policies and allocation of resources to serve people diagnosed with mental illnesses and to invite greater collaboration across agencies and service systems utilizing

DMH as the locus of mental health expertise and direction. For consumers and their families, mental health services needed to be integrated with other health and human services so as to appear seamless in access when needed.

The ideal system of care in Illinois would be characterized by:

- 1) A focus on recovery as the goal of service delivery, emphasizing outcomes rather than the services themselves;
- 2) Data-driven policy and program decisions based upon an improved capacity to analyze and disseminate relevant information;
- 3) Individualized service planning with the active participation of the consumer with emphasis on his/her choice of what services are most needed at any particular point; and,
- 4) An increased role for mental health consumers and advocates in shaping mental health policy, including more influence in the allocation of scarce health and human services resources.

The initiatives and informant group activities which took place in 2004 and 2005 set the stage for two comprehensive state planning meetings which occurred in FY2007. The goals of the Director of the Division of Mental Health, Dr. Lorrie Rickman Jones, in convening these meetings were straightforward and clearly based on the developments and feedback of the preceding years:

- To renew collective commitment to collaborating in the interest of the system.
- To reach consensus regarding the vision/values that underlie mental health service delivery (establishment of recovery as a unifying principle).
- To prioritize cross-cutting goals for quality mental health services that span multiple agencies.

After extensive discussion, the following mission and vision statements were composed and presented for approval:

#### **Mission Statement:**

**“Illinois envisions a well resourced and transformed mental health system that is consumer directed and community driven with a continuum of integrated and effective culturally inclusive programs, services (prevention, early intervention and treatment) and supports that promote healthy lifelong development through equal access, and that supports recovery and resilience.”**

#### **Vision Statement**

**The Illinois Vision for Mental Health is "The Expectation of Resilience and Recovery through Treatment, Accountability and Equal Access"**

In July, 2008 a leadership staff retreat on Strategic Transformation was attended by the Director of DMH, the Chief of Staff and more than thirty clinical, community, and hospital administrative staff from Chicago and Springfield offices and each DHS region. The purpose of the retreat was to further advance the transformation of DMH's services to adhere and align with the vision of ***Recovery as the Expectation*** for consumers of

mental health services in Illinois. Designed and facilitated to promote staff learning and engagement about transformative initiatives within DMH, the Strategic Transformation Retreat featured presentations on clinical services for children and adolescents, juvenile and adult forensic services, hospital-based services and community situated, evidence-based services for adults seeking housing and employment, quality improvement and using data for decision making and to evaluate the Division's transformation efforts. Additionally, training exercises were conducted to empower staff leadership.

The Division of Mental Health (DMH), in collaboration with state agencies and stakeholders, is moving forward with a comprehensive cross-system planning approach for public mental health services which emphasizes effective coordination of services, cohesiveness, and the principles of the Recovery Model for the provision of clinical and supportive mental health services

The Table that follows provides an overview of the initiatives which DMH is currently undertaking to move the transformation of the public mental health service system forward.

**TABLE 1: DMH TRANSFORMATION INITIATIVES**

<b>Goal 1:</b> Americans must understand that mental health is essential to overall health	<b>Goal 2:</b> Mental health care must be consumer and family driven	<b>Goal 3:</b> Disparities in mental health services must be eliminated	<b>Goal 4:</b> Early mental health screening, assessment and referral to services	<b>Goal 5:</b> Excellent mental health care must be delivered and research accelerated	<b>Goal 6:</b> Technology must be used to access mental health care and information
<b>Integration of primary healthcare and mental health</b> <ul style="list-style-type: none"> <li>■ WRAP training</li> <li>■ Consumer Conferences</li> <li>■ Statewide Consumer Calls</li> <li>■ Administrative Services Contract</li> <li>■ Disease Management Collaboration</li> <li>■ Public Awareness Campaign</li> </ul>	<b>Build consensus on recovery</b> <ul style="list-style-type: none"> <li>■ WRAP training</li> <li>■ Consumer Conferences</li> <li>■ Statewide Consumer Calls</li> <li>■ Administrative Services Contract</li> <li>■ Disease Management Collaboration</li> <li>■ Public Awareness Campaign</li> </ul>	<b>Diversion from Criminal Justice</b> <ul style="list-style-type: none"> <li>■ Mental Health Courts</li> <li>■ Jail Data Link</li> <li>■ MHJJ Initiative</li> </ul>	<b>Screening, prevention and early intervention</b> <ul style="list-style-type: none"> <li>■ 10 grants awarded-FY07 and FY08 at \$1M</li> <li>■ School Violence Initiative</li> <li>■ SASS</li> <li>■ Returning Veterans Initiative</li> </ul>	<b>Promotion and expansion of evidence based practices</b> <ul style="list-style-type: none"> <li>■ Social Work Curriculum Initiative</li> <li>■ Supported Employment Initiative</li> <li>■ IDDT Grant</li> <li>■ Medication Algorithms</li> <li>■ Evidence Informed Practice</li> <li>■ Seclusion and Restraint</li> <li>■ TTI Forensic Initiative</li> </ul>	<b>Technology plans</b> <ul style="list-style-type: none"> <li>■ EHR Taskforce</li> <li>■ Telepsychiatry Pilot</li> <li>■ Implement New Provider Reporting and Billing Systems</li> </ul>

## Adult Plan

### **Transformation Activities in FY2009: Achieving the Promise**

Overall, the DMH vision for the community mental health system is one that is oriented towards fostering resilience and recovery, and one that is consumer and family driven. It is our belief that system transformation, as all constructive endeavors, must be based on an assessment of needs, available strengths from which to build and change, and a set of priorities that provide clear direction and lend structure to the process and the activities aimed toward positive results. The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in this regard. The Adult Plan addresses the following New Freedom Commission goals:

#### **Americans understand that mental health is essential to overall health.**

- ❖ Affirming the state's vision of Recovery is an essential feature of this goal. DMH will do this by actively providing recovery oriented training to all interested stakeholders and supporting the role and credentialing of Certified Recovery Support Specialists (CRSS). (See Objective A1.3)
- ❖ DMH is continuing to advance and expand the public awareness campaign to reduce the negative portrayals associated with mental illnesses. (See Objective A1.9)
- ❖ DMH is partnering with staff of the Illinois Department of Healthcare and Family Services (DHFS) in implementing a federal Medical Emergency Room Diversion (ERD) Grant from CMS. The grant provides \$2 million over a two-year period to improve access to, and quality of, primary health care services through peer-delivered crisis response services. Through the grant, two new Community Health Center (CHC) sites will be located on or near hospital campuses which will partner with behavioral health providers so consumers seeking non-emergent care may be seen in a non-emergent primary care and behavioral health setting. Two collaborations will be funded, one in Chicago and one in an area serving rural citizens. (See Section II, Criterion 1)

#### **Mental health care is consumer and family driven.**

- ❖ Consistent with the priority noted above, the DMH Office of Recovery Services will continue enhancement of the statewide system to educate consumers of mental health services in leadership, personal responsibility and self-advocacy through participation in Consumer Conferences, the use of Wellness Recovery Action Plans (WRAP), and through the Consumer Education and Support Initiative. (See Objectives A1.1 and A1.2)
- ❖ In FY2009, the Office of Recovery Support Services will work with other system partners, including the ICB and the Mental Health Collaborative for Access and Choice (MHCAC), to develop training and study materials for those seeking to

obtain their CRSS and with provider agencies and trade associations to develop employment opportunities.

**Disparities in mental health services are eliminated.**

- ❖ The DMH continues to pursue the goal of increasing access to services by adults with serious mental illnesses. In FY2005, 56.5% of adults receiving services met DMH criteria for target population. This percentage has remained constant through FY2007. (FY2008 data will be provided in the implementation report.) (See Performance Indicator A2.4- Increased Access to Services by the DMH Target Population)
- ❖ The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY2007, 93.6% of adults receiving services met the eligible population criteria (132,787 of 141,806 adults served). DMH continues to focus on this indicator in FY2009. (See Performance Indicator A2.5 -Increased Access to Services by the DMH Eligible Population.)
- ❖ Consistent with this important NFC goal, the DMH continues to track data on gender, race/ethnicity, and age as a means discovering, analyzing, and solving disparity issues. (See: Performance Indicators A2.1(NOM)-Number Of Adults Served By Gender (Access to Services); A2.2(NOM)- Number Of Adults Served By Race/Ethnicity Access to Services); A2.3(NOM)-Number Of Adults Receiving Services By Age (Access to Services).
- ❖ The number of homeless adults accessing DMH-funded services has been tracked for many years. In FY 2007, there were 7,639 homeless adults receiving DMH funded services which represents a substantial increase (15%) over the number of persons accessing service in FY 2006. We will continue to track this information in FY2009. (See System Performance Indicator A4.1)
- ❖ The number of adults living in the 76 rural counties of Illinois who receive DMH-funded services is tracked on an ongoing basis and an increase in number has been evident. By FY 2005, the number had increased by 3,500 individuals since this system performance indicator was first established. In FY2006 a 5% (32,280) increase in the number of rural residents receiving services was noted. The latest number reported (for FY2007) reflected a nearly 8% increase to 34,807. Tracking and efforts to increase the number of adults in rural areas receiving services will continue to be a priority. (See System Performance Indicator A4.2)
- ❖ The DMH collaborates closely with the Illinois Department On Aging (IDOA) to improve access to mental health services by older adults. In FY2009, the DMH and the IDOA continue to convene meetings with stakeholders to plan services for older adults and expand treatment options such as the GeroPsychiatry program. (See Objective A4.3)

**Early mental health screening, assessment, and referral to services are common practice.**

- ❖ DMH Forensic Services will continue to expedite, facilitate, monitor and coordinate services to persons with serious mental illnesses in the criminal justice system. Those found unfit to stand trial or not guilty by reason of insanity and treated in state operated mental health facilities require timely restoration of fitness to conclude court involvement and reentry to community services at the earliest possible time. Case finding, data coordination, planned linkages and services through Mental Health Courts are being advanced to meet the mental health needs of persons detained in county jails and incarcerated in the Illinois Department of Corrections.
- ❖ In FY2009, DMH Forensic Services will complete a statewide needs assessment and system mapping initiative funded by a Transformation Transfer Initiative Grant for individuals with mental illness or co-occurring mental health and substance abuse disorders who are involved with the criminal justice system. (See Objective A1.10)
- ❖ In FY2008, \$236,000 in federal Project for Assistance in the Transition from Homelessness (PATH) funding was redirected to provide case management services to 185 additional adults who are homeless and who are PATH eligible. The increase in case management is being targeted to homeless persons with mental illnesses being released from jail. PATH providers have projected a substantive increase in the number of clients served in FY2009 that is based upon new procedural efficiencies and the expansion of available resources through increased community collaboration. (See Objective A4.1)
- ❖ The DMH will continue to emphasize Mental Health and Law Enforcement Training by collaborating with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to persons in crisis.

**Excellent mental health care is delivered and research is accelerated.**

- ❖ The DMH is continuing its work on advancing evidence-based practice in Illinois (See Objectives A1.4 through A1.8):
  - By the end of FY2009, through the provision of rental subsidies, DMH will implement a statewide permanent supportive housing initiative which targets 600 consumers in the next three years to acquire decent, safe, and affordable housing and support services in a manner consistent with the national standards for this evidence based practice.
  - During FY 2009, training and implementation in the use of medication algorithms will be increased and expanded to additional agencies.

Coordination of medication algorithms between Community Mental Health Centers and State Operated Hospitals for the purpose of continuity of care will be undertaken for the first time. Consistency in medication management practices can improve patient outcomes in the continuum of treatment that begins in state operated facilities and continues with community mental health providers.

- An effort will be made to strengthen fidelity and support the provision of ACT services.
  - DMH and DRS are committed to implementing and expanding supported employment.
  - Planning to implement family psychoeducation continues.
  - Joint planning with DASA for services to persons with co-occurring disorders will build upon the lessons learned from the Integrated Dual Diagnosis Treatment (IDDT) project.
  - DMH staff are engaged in planning the development and implementation of Illness Management and Recovery (IMR) within the state.
- ❖ In FY2009, the DMH will continue to work on increasing Medicaid funding for the Illinois mental health service system. Barriers to increasing Medicaid billing and to enhancing eligibility for clients who use DMH funded mental health services (including patients in state psychiatric hospitals need to be identified and eliminated. Medicaid policies and procedures need to be clarified and the documentation requirements of providers streamlined. Work will continue in developing and maintaining a system for utilization management within the Medicaid program and the implementation of fee-for-service funding. (See Objective A5.1)

#### **Technology is used to access mental health care and information.**

- ❖ DHS MIS staff are working with DMH staff to migrate to a web-based data collection platform. The first step in this initiative has been to convert the collection of PAS/MH data from a diskette-based reporting system to a web-based data reporting system. In FY2009, this work on this initiative will continue to expand.
- ❖ As noted in Section 1, DHS/DMH reconfigured administrative services through an administrative services organization, the Mental Health Collaborative for Access and Choice (MHCAC) in FY2008. One of the major responsibilities of the MHCAC in FY2009 is to implement a state-of-the-art management information system (MIS) which supports a range of data related functions including consumer enrollment, service utilization, provider claims submission, validation, processing, adjudication, and payment through reliable, valid, and expeditious data transmission among all appropriate federal, state, and local entities. The MHCAC will also provide for access to this data by developing a data warehouse that is accessible to DMH staff.

- ❖ DMH is moving forward to develop and solidify the infrastructure and introduce the technology necessary for the successful use of tele-psychiatry, particularly in rural areas in which there is a shortage of psychiatrists and other needed mental health clinicians. Internet access, video conferencing, and other applications provide an opportunity to enhance the quality of care in rural mental health services.

## **Child Plan**

### **Transformation Activities in FY2009: Achieving the Promise**

Overall, the DMH vision for the community mental health system is one that is oriented towards fostering resilience and recovery, and one that is consumer and family driven. It is our belief that system transformation, as all constructive endeavors, must be based on an assessment of needs, available strengths from which to build and change, and a set of priorities that provide clear direction and lend structure to the process. The Report of the President's New Freedom Commission on Mental Health provides an important foundation for on-going planning efforts in service integration for children and adolescents. The service system priority continues to be one of collaboration to provide a seamless system of care, given the multiple problems of children and adolescents, as well as their families, who are involved with overlapping service systems. The FY2009 Children's Plan addresses the following New Freedom Commission goals and some of the key initiatives and activities are highlighted:

#### **Americans understand that mental health is essential to overall health.**

- ❖ DMH is advancing a public awareness campaign to reduce the stigma experienced by children/adolescents and their families associated with mental illnesses. Funding has been obtained through collaboration with the Illinois Children's Mental Health Partnership (See Objective C1.5.).

#### **Mental health care is consumer and family driven.**

- ❖ DMH C&A Services is continuing to work with parents and parent-led organizations to facilitate parent-to-parent support through the use of Family Resource Developers (FRD's), to increase the number of FRD's employed in child-serving mental health agencies, and to encourage substantive feedback from parents and parent led organization on enhancing the quality of services at all levels of care. (See Objective C1.1)
- ❖ Efforts to enhance and integrate the role and contribution of the DMH C&A Teen Advisory Group will also continue. (See Objective C1.2.)

#### **Disparities in mental health services are eliminated.**

- ❖ The DMH continues efforts to increase access to services by children and adolescents with serious emotional disturbance. In FY2005, the percentage of

children and adolescents meeting the criteria for the DMH target population was 30.4% and had increased by FY2007 to 33.3%. (Data for FY 2008 will be provided in the implementation report.) Also, note that this is likely an underestimate due to the fact that the DMH is still unable to access SASS data. (See Performance Indicator C2.1- Increased Access to Services by the DMH Child/Adolescent Target Population)

- ❖ The definition of the DMH eligible population is somewhat broader than the definition for the target population. In FY2005, the percentage of children and adolescents meeting the DMH eligible population criteria was 88.2%. DMH continues to focus on this indicator in FY2009. (See Performance Indicator C2.2- Increased Access to Services by the DMH Eligible C& A Population)
- ❖ The Mental Health Juvenile Justice (MHJJ) initiative will continue work to increase the number of juvenile detainees with serious mental illnesses who are identified, screened, and linked with appropriate community-based services. (See Objective C3.1) Evaluation of the MHJJ program has found that these services result in overall clinical improvement, decreased functional impairment and reduced rates of recidivism for youths enrolled in the program. Based upon evaluation findings, the program will work on increasing the clinical services that have been found to be most strongly associated with positive outcomes, increasing the number of service sessions provided for Black and Hispanic youth, and increasing the number of minority youth referred to the MHJJ program.
- ❖ DMH continues to track the number of homeless youth entering community-based services. The number of youth reported has steadily decreased since FY 2005. In FY2007, 300 youth were reported as undomiciled. (See System Performance Indicator C4.1)
- ❖ The DMH continues to track the number of rural youth served (see System Performance Indicator C4.2) in the public mental health system. There appears to be a trend toward increased access of services by this population. In FY2005, 10,247 youth received services and 11,590 in FY2007 – an increase of 13%.

#### **Early mental health screening, assessment, and referral to services are common practice.**

- ❖ During FY2008 DMH, in collaboration with ICMHP, awarded \$100,000 to one provider in each of the five DHS regions to develop and provide Mental Health Early Intervention Services for Children and Adolescents. Implementation of FY 2008 grant awards paired with the five (5) pilot projects introduced in FY 2007 resulted in a total of ten (10) pilot sites and \$1,000,000 in statewide funding. A major goal of this initiative is to identify and engage children and adolescents with mental illness or social/emotional problems who are untreated, and those at risk of serious emotional disturbance or social/emotional problems. The overall objectives of this initiative are to implement a statewide system of early intervention services and to develop a network of providers who will be able to

identify best practice models through their experience. (See Objective C3.3)

- ❖ Community service options in the DMH ICG program will be further strengthened in FY2009 and the number of youth served is expected to increase. (See Objective C1.3)
- ❖ During FY2008, DMH, in collaboration with ICMHP, DMH awarded \$100,000 to one successful bidder in each of the five DHS regions. to develop and provide mental health services that address the unique and special needs of older adolescents (16-17 years old) with SED who are transitioning from C&A services to adult services and for any youth with SED who is transitioning from correctional services to the community. Implementation of FY 2008 grant awards paired with the five (5) pilot projects introduced in FY2007 resulted in a total of ten (10) pilot sites and \$1,000,000 in statewide funding. In addition to providing an array of mental health services all projects are expected to build community infrastructure that will facilitate and support expansion of transition services for youth and the effectiveness of services, as well as development of a system of care for transitioning youth. (See Objective C3.2).
- ❖ The DMH will continue to emphasize Mental Health and Law Enforcement Training by collaborating with law enforcement agencies and emergency services at general hospitals to facilitate appropriate and effective psychiatric intervention to youth and support to families in crisis.

**Excellent mental health care is delivered and research is accelerated.**

- ❖ As noted above, DMH is committed to advancing the implementation of evidence-informed practices in the child and adolescent service system through training events and a clearly laid out curriculum based upon research and practice experience. (See Objective C1.3).
- ❖ Training in trauma-informed service provision is being provided to child mental health providers, child welfare, and juvenile justice staff through a collaborative effort with DCFS and ICMHP.
- ❖ Early Childhood Mental Health assessment and treatment services for children ages 0-5 and their families is being prioritized in FY2009 with the establishment and continuing support of five pilot sites across the State and collaboration with the ICMHP to provide early childhood consultation statewide. (See Objective C3.4)
- ❖ DMH will continue to work on increasing Medicaid funding for the Illinois mental health service system. Barriers to increasing Medicaid billing and to enhancing eligibility for consumers who use DMH funded mental health services (including patients in state psychiatric hospitals) need to be identified and eliminated. Medicaid policies and procedures need to be clarified and the documentation requirements of providers streamlined. Work will continue in developing and

maintaining a system for utilization management within the Medicaid program and the implementation of fee-for-service funding. (See Objective C5.1)

**Technology is used to access mental health care and information.**

- ❖ The Child and Adolescent Outcomes Analysis system is being implemented in FY2009. It is a Web-based system that will feature the ability to generate immediate feedback at the individual, agency, and statewide levels. (See Objective C2.1)
- ❖ As noted in Section 1, DHS/DMH reconfigured administrative services through an administrative services organization, the Mental Health Collaborative for Access and Choice (MHCAC) in FY2008. One of the major responsibilities of the MHCAC in FY2009 is to work with DMH staff to implement a state-of-the-art management information system (MIS) which supports a range of data related functions including consumer enrollment, service utilization, provider claims submission, validation, processing, adjudication, and payment through reliable, valid, and expeditious data transmission among all appropriate federal, state, and local entities. The MHCAC will also provide for access to this data by developing a data warehouse that is accessible to DMH staff.
- ❖ DMH C&A Services is implementing a telepsychiatry pilot project in seven rural sites in Illinois and assessing service utilization and the need for further enhancement and expansion in FY2010. (See Objective C4.1)



## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	129,567	141,807	142,000	142,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To monitor access to services.
- Target:** Maintain access to services for adults with mental illnesses at the FY 2008 level.
- Population:** Adults with mental illnesses.
- Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services
- Indicator:** Number of adults served.
- Measure:** Number of adults receiving services from DMH-funded community-based providers.
- Sources of Information:** Reporting of Community Services (RoCS). This indicator is generated from URS Tables 2A and 2B.
- Special Issues:** Illinois is making major changes to the mental health system this year. As noted in the narrative, the DMH has contracted with an Administrative Services Organization, the MIS is being revamped and some services are now being preauthorized. At this point in time, we are tracking access to services to assure that the level of access that currently exists will be maintained. Therefore the target for FY 2009 is the same as that established for FY 2008.
- Significance:** Adults with mental illnesses should have access to treatment.
- Action Plan:** DMH will continue to track the number of persons receiving services from DMH-funded community-based providers in FY 2009. The data will be submitted via the URS and will continue to be partitioned by gender, age and race/ethnicity.

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	13.48	15.99	15	15	N/A	N/A
Numerator	1,537	1,785	--	--	--	--
Denominator	11,402	11,165	--	--	--	--

Table Descriptors:

<b>Goal:</b>	To encourage assurance of sufficient clinical stabilization of individuals discharged to community programs from DMH state hospitals through the provision of alternative community-based services.
<b>Target:</b>	Decrease readmissions within 30 days to state hospitals.
<b>Population:</b>	Adults with serious mental illness.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems 3:Children's Services
<b>Indicator:</b>	Decreased Rate of Civil Readmissions to State Psychiatric Hospitals within 30 days. Numerator: Number of civil readmissions to any state hospital within 30 days. Denominator: Total number of civil discharges in the year.
<b>Measure:</b>	Numerator: Number of adults readmitted to a state hospital within thirty days of being discharged from a state hospital. Denominator: Number of persons discharged from a state hospital in a fiscal year.
<b>Sources of Information:</b>	Inpatient Clinical Information System (CIS). This indicator is generated from URS Table 20A.
<b>Special Issues:</b>	
<b>Significance:</b>	
<b>Action Plan:</b>	DMH will continue to monitor the number of adults readmitted to state hospitals within 30 days of discharge with a FY 2009 goal of decreasing the level of re-hospitalization by providing services in the community that provide alternatives to re-hospitalization.

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	13.48	11.43	11	11	N/A	N/A
Numerator	1,537	1,276	--	--	--	--
Denominator	11,402	11,165	--	--	--	--

Table Descriptors:

- Goal:** To encourage assurance of sufficient clinical stabilization of individuals discharged to community programs from DMH state hospitals through the provision of alternative community-based services.
- Target:** Decrease rate of 180 day readmissions
- Population:** Adults with Serious mental illnesses.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Decreased Rate of Civil Readmissions to State Psychiatric Hospitals within 180 days.
- Measure:** Numerator: Number of civil readmissions to any state hospital within 180 days.  
Denominator: Total number of civil discharges in the year.
- Sources of Information:** Inpatient Clinical Information System. This indicator is generated from URS Table 20A.
- Special Issues:**
- Significance:**
- Action Plan:** DMH will continue to monitor the number of adults readmitted to state hospitals within 180 days of discharge with a FY 2009 goal of decreasing the level of re-hospitalization by providing services in the community that provide alternatives to re-hospitalization.

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	0	0	150	N/A	N/A
Numerator	N/A	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Provide Permanent Supported Housing to adults needing these services
- Target:** Increase the number of individuals with SMI receiving permanent supportive housing by 150 in FY 2009
- Population:** Adults with serious mental illnesses
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of adults with SMI receiving SED
- Measure:** Numerator: Number of adults with SMI receiving permanent supported housing.
- Sources of Information:** Will begin collecting authorization information in FY 2009; This indicator will be generated from URS Table 16.
- Special Issues:**
- Significance:** Adults with serious mental illnesses who are in need of supported permanent housing should have access to it.
- Action Plan:** The DMH is currently working to implement Permanent Supportive Housing. Meetings held with key stakeholders and consultants such as the technical assistance collaborative and the supportive housing agencies in Illinois finalized planning during FY 2008 and 150 consumers will be housed through PSH in FY 2009. (See objective A1.4 in Section III-A)

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	373	0	1,096	N/A	N/A	N/A
Numerator	N/A	0	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Provide Supported Employment to individuals with SMI who want to receive this service.
- Target:** Maintain availability of permanent supportive housing to those individuals receiving it. Webbgas would not permit the update of information for FY 2008. The number should be 1096.
- Population:** Adults with serious mental illnesses
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of persons with SMI receiving supported employment.
- Measure:** Numerator: Number of adults with SMI receiving supported employment
- Sources of Information:** Reports submitted by 11 agencies as part of SE pilot projects. The indicator will be generated from URS Table 16.
- Special Issues:** Data is not yet integrated into DMH reporting system; Data is being collected as part of a pilot project.
- Significance:** Adults with serious mental illnesses who want to work should; Supported employment supports adults with SMI in their recovery.
- Action Plan:** Continue to provide training to SE pilot agencies, including technical assistance/consultation. (See objective A1.6 in Section III-A)

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	3,529	N/A	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Provide access to assertive community treatment (Please note that the number of persons receiving ACT in FY 2008 was 2,904. Webbgas would not accept this update.)
- Target:** No target is being projected for FY 2009 due to the fact that ACT is being revamped within the state to ensure that the EBP is meeting fidelity to the national model. We will consider establishing a target once data is generated for FY 2008.
- Population:** Adults with serious mental illnesses with multiple psychiatric hospitalizations
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Numerator: Number of adults with SMI receiving ACT
- Measure:** Number of adults with SMI receiving ACT
- Sources of Information:** Reporting of community services systsem; This indicator will be generated from URS Table 16.
- Special Issues:** The DMH is undertaking an effort to ensure that evidence-based assertive community treatment is being provided. There will be a focus on assessing the fidelity of the service. Many ACT teams are currently being converted to community support services by community agencies; therefore it is expected that the number of teams (currently 50) and the number of individuals receiving these services will be greatly reduced during the next fiscal year. (See objective A1.7,Section III-A).
- Significance:** ACT should be available to individuals who will benefit from this service
- Action Plan:** DMH will collect data during the next fiscal year to establish a new baseline for this indicator.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Indicator Not Applicable: Currently developing a plan to implement family psychoeducation
- Target:** No target; planning underway to implement
- Population:** Adults with serious mental illnesses.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of adults with SMI receiving family psychoeducation
- Measure:** Number of adults with SMI receiving family psychoeducation
- Sources of Information:** Not currently collected.
- Special Issues:** Planning is occurring; not yet implemented
- Significance:**
- Action Plan:** Not currently implemented; planning is occurring (See objective A1.8).

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	0	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Not Currently Applicable; DMH is undertaking planning to continue implementation of IDDT.
- Target:** Not Applicable--Zero; still in process of implementing
- Population:** Adults with co-occurring serious mental illnesses and substance use disorders
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Numerator: Number of Individuals receiving IDDT services
- Measure:** Number of Individuals receiving IDDT/MISA
- Sources of Information:** Not available
- Special Issues:** IDDT/MISA is one of the more difficult EBPs to implement. The DMH has been working on a pilot project to implement this EBP.
- Significance:** It has been estimated that 50% or more of individuals with serious mental illnesses have co-occurring substance abuse disorders. Integrated treatment is the most effective means of treating these disorders.
- Action Plan:** The DMH will continue its efforts to implement IDDT/MISA during FY 2009.

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

**Goal:** Availability of Illness Self Management - Not Applicable

**Target:** Zero; Continuing efforts to implement this EBP

**Population:** Adults with SMI

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Numerator: Number of individuals receiving Illness Self Management.

**Measure:** Number of individuals receiving Illness Self Management

**Sources of Information:** Not currently collected

**Special Issues:**

**Significance:** Illness self-management should be accessible to individuals with serious mental illnesses

**Action Plan:** The DMH will continue its work on planning for implementation of this service.

## ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** NOT APPLICABLE--Availability of medication management
- Target:** Zero; The DMH will continue working on efforts to strengthen its work in this area; We anticipate reporting perhaps in FY10.
- Population:** Individuals with serious mental illnesses with specified diagnoses receiving psychotropic medication
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Numerator: Number of individuals receiving medication management.  
Denominator: Total unduplicated number of adults with SMI served by DMH funded care.
- Measure:** Number of individuals receiving medication management
- Sources of Information:** None currently -- not collected
- Special Issues:**
- Significance:** Medication management is a key to the provision of service resulting in positive outcomes for certain diagnoses
- Action Plan:** The DMH will continue its work to implement medication algorithms in state hospitals and community agencies during FY 2009. (See objective A1.5, Section III-A.)

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	76.27	63.03	63	68	N/A	N/A
Numerator	768	300	--	--	--	--
Denominator	1,007	476	--	--	--	--

Table Descriptors:

- Goal:** Increase perception of positive treatment outcomes
- Target:** Increase perception of positive treatment outcomes by 3%
- Population:** Adults with mental illnesses receiving mental health treatment
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of adult consumers reporting positively about outcomes.
- Measure:** Numerator: Number of adult consumers reporting positively about outcomes using the MHSIP Adult Survey  
Denominator: Total number of adult consumer responses regarding perceptions of outcomes. completing the MHSIP Adult Survey
- Sources of Information:** MHSIP Adult Consumer Survey - Reported in Table 11 URS Tables - A survey was sent to 2955 adults receiving services in June of 2007. 2525 were valid addresses. 497 Completed surveys (19%) were returned.
- Special Issues:**
- Significance:** Mental health services should result in positive outcomes
- Action Plan:** Implement consumer survey in September 2008 and complete in time for FY 2008 Implementation Report.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	23.25	23.43	23	23	N/A	N/A
Numerator	27,240	30,004	--	--	--	--
Denominator	117,184	128,081	--	--	--	--

Table Descriptors:

- Goal:** Increase in competitive employment status by adults with mental illnesses receiving treatment
- Target:** Maintain competitive employment rate (Currently this data is only collected at intake prior to treatment, therefore there is no expectation that there will be an increase. Such a target will be set when we begin collecting data at T1 and T2.)
- Population:** Adults with mental illnesses receiving treatment
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percent of adult clients who are competitively employed.
- Measure:** Numerator: Number of adult consumers competitively employed full or part-time (includes supported employment). Denominator: Number of adult consumers competitively employed full or part-time (includes Supported Employment) plus number of persons unemployed plus number of persons not in labor force (includes retired, sheltered employment, sheltered workshops, and other) This does not include persons whose employment status is "not Available".
- Sources of Information:** Employment Status at case opening is collected via Reporting of community services system
- Special Issues:** Change in status requires the ability to collect data at multiple points in time. These issues are still being discussed by the states, NRI and CMHS
- Significance:** Employment is an important variable contributing to recovery
- Action Plan:** Employment status for individuals receiving treatment will be collected and updated at 6 mos. intervals beginning January 2009. Until baseline data is captured and reviewed, we will continue tracking this information at intake. Employment status will continue to be reported on URS Table 4.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	66.67	0	N/A	N/A	N/A
Numerator	0	14	--	--	--	--
Denominator	N/A	21	--	--	--	--

Table Descriptors:

- Goal:** Decreased involvement with the justice system by adults with serious mental illnesses
- Target:** No target established - This measure was collected using the MHSIP Consumer Survey in 2007
- Population:** Adults with serious mental illnesses who have had involvement with the justice system
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent of adult consumers arrested in Year 1 who were not rearrested in Year 2.
- Measure:** Numerator: Number of adult consumers arrested in T1 who were not rearrested in T2 (new and continuing clients combined).  
Denominator: Number of adult consumers arrested in T1 (new and continuing clients combined).
- Sources of Information:** This indicator was collected using the MHSIP Survey in FY 2007 and will be collected again by this method in FY 2008.
- Special Issues:**
- Significance:** There is an expectation that adults receiving mental health services who have been involved with the justice system will decrease this involvement, however questions remain regarding the appropriate measure.
- Action Plan:** Illinois will collect this data using the MHSIP Consumer Survey in 2008; however, due to the small response rate and the developmental nature of the measure NO target has been established for FY 2008.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	5.01	5.03	5	5	N/A	N/A
Numerator	5,872	6,649	--	--	--	--
Denominator	117,177	132,060	--	--	--	--

Table Descriptors:

- Goal:** Improve stability of housing for adults with serious mental illnesses
- Target:** Track stability in housing information; this data is collected at intake prior to treatment so we do not expect change to occur. Once we begin to track data at T1 and T2 we will specify a target.
- Population:** Adults with serious mental illnesses
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent of adult consumers who are homeless or living in shelters.
- Measure:** Numerator: Number of adult consumers who are homeless or living in shelters.  
Denominator: All adult consumers with living situation excluding persons with Living Situation Not Available.
- Sources of Information:** ROCS System; This indicator is generated from URS Table 15.
- Special Issues:**
- Significance:** Adults with serious mental illnesses should have access to stable living environments.
- Action Plan:** The DMH will continue working with CMHS, NRI and the states to better define ways to collect this data (see capacity checklist). Status will be reported on Table 15 of the URS tables.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	63.06	N/A	N/A	N/A	N/A
Numerator	0	297	--	--	--	--
Denominator	N/A	471	--	--	--	--

Table Descriptors:

- Goal:** Increased perception of social support/connectedness for individuals participating in treatment
- Target:** None - Developmental Measure - No basis on which to set target.
- Population:** Adults with serious mental illnesses
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent of adult consumers reporting positively about social supports/social connectedness.
- Measure:** Numerator: Number of adult consumers reporting positively about social connectedness.  
Denominator: Total number of family responses regarding social connectedness.
- Sources of Information:** This information was collected as a component of the Adult MHSIP Survey collected for FY 2007. A survey was sent to 2955 adults who were consumers in June 2007. 2525 were valid contact addresses. 497 completed surveys (19%) were returned.
- Special Issues:** This indicator is developmental and still being refined.
- Significance:** Availability of social support may be related to support for recovery.
- Action Plan:** The DMH will continue to work with CMHS, NRI and the states to refine this indicator. We will also use the questions that have been developed in the next round of the Adult MHSIP Consumer Survey.

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	61.47	0	N/A	N/A	N/A
Numerator	0	292	--	--	--	--
Denominator	N/A	475	--	--	--	--

Table Descriptors:

**Goal:** Improved functioning for adults with mental illnesses receiving services

**Target:** None - Developmental Measure - No basis on which to set target.

**Population:** Adults with mental illnesses receiving treatment

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems

3:Children's Services

4:Targeted Services to Rural and Homeless Populations

**Indicator:** Percent of adult consumers reporting positively about functioning.

**Measure:** Numerator: Number of adult consumers reporting positively about functioning.

Denominator: Total number of adult consumer responses regarding functioning.

**Sources of Information:** MSHIP Consumer Survey; This indicator is generated from URS Table 11.

**Special Issues:**

**Significance:** Mental health services should result in improved functioning and reduction in symptoms.

**Action Plan:** Continue working with the NRI, CMHS and the states to refine/develop this indicator.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

### **Name of Performance Indicator: ACT SERVICE HOURS IN COMMUNITY**

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	65	67	67	67	N/A	N/A
Numerator	144,441	143,527	--	--	--	--
Denominator	221,360	214,280	--	--	--	--

#### Table Descriptors:

- Goal:** To assure that a significant portion of the service delivered within the (ACT) programs are provided in the most normalized settings possible in the individual's community, rather than within the provider's offices or clinics.
- Target:** Maintain delivery of services in community locations at the 67% level.
- Population:** Adults with serious mental illnesses.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of service hours for adults being served by the DMH-funded Assertive Community Treatment (ACT) Programs, who receive services outside of the provider's offices or clinics.
- Measure:** Numerator: The number of hours of service provided by the DMH-funded (ACT) Programs which occur outside of the provider's offices or clinics.  
Denominator: The total number of hours of service provided by the DMH-funded (ACT) Programs.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:** ACT services are being revamped in Illinois with an eye toward assuring that services delivered have fidelity to the EBP model.
- Significance:**
- Action Plan:** DMH will continue to monitor service provision of ACT programs in order to maintain current levels of services delivered in community settings outside of the provider's offices or clinics.

## ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

### Name of Performance Indicator: CASE MANAGEMENT

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	48.60	46.90	0	0	N/A	N/A
Numerator	38,491	40,423	--	--	--	--
Denominator	79,245	86,161	--	--	--	--

### Table Descriptors:

- Goal:** To maintain access to case management services to individuals with specific serious mental illnesses being served in the DMH-funded community-based service system.
- Target:** No target established for FY 2008 or FY 2009.
- Population:** Adult's with mental illnesses.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adults being served by the DMH-funded community-based service system with an initial DSM-IV diagnosis of 295.xx or 296.xx who receive case management services.
- Measure:** Numerator: Adults being served by the DMH-funded community-based service system with an initial DSM- IV diagnosis of 295.xx or 296.xx receiving case management services.  
Denominator: All adults being served by the DMH-funded community-based service system with an initial DSM-IV diagnosis of 295.xx or 296.xx.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:** DMH has recently revamped its Services taxonomy. There is an expectation that many case management services will be subsumed in "Community Support Services". Therefore, we will track the amount of case management services provided in FY 2008. No projection made FOR fy 2008. DMH will consider setting a target for FY 2009 upon review of the FY 2008 data.
- Significance:** There is a direct relationship between the amount of case management services provided and resilience and recovery rates for some diagnoses.
- Action Plan:** DMH will continue to track the amount of case management services provided but reestablish its baseline in FY 2009.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

### **Name of Performance Indicator: CO-OCCURRING DISORDERS -ADULTS**

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	12.10	12.36	12.10	12.10	N/A	N/A
Numerator	15,610	17,532	--	--	--	--
Denominator	129,564	141,807	--	--	--	--

#### Table Descriptors:

- Goal:** To increase community-based mental health services for persons who have co-occurring mental health and substance abuse disorders.
- Target:** Identification of percentage of adults with co-occurring disorders at time of intake and reported through the Reporting of Community Services (RoCS) data collection system. No change expected as this is a point in time measure collected at intake.
- Population:** Adults with mental illness.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adults served with a co-occurring disorders based on diagnostic category.
- Measure:** Numerator: Number of adults served in the community with a co-occurring mental health and substance abuse diagnosis at intake.  
Denominator: Total number of adults served in the fiscal year.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** DMH reporting of community services data shows that a little over 12% of DMH consumers have been identified at intake as having a substance abuse and a mental health diagnosis. This is likely to be under-estimated and demonstrates the importance of ongoing training in identifying and treating persons with dual disorders (MISA).
- Action Plan:** DMH plans to continue to encourage and support increased training for community mental health professionals in the identification, reporting and treatment of co-occurring disorders. Continue to track number of individuals reported with co-occurring disorders.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

### **Name of Performance Indicator: ELIGIBLE POPULATION - ADULTS**

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	94.20	94	95	95	N/A	N/A
Numerator	122,029	132,787	--	--	--	--
Denominator	129,564	141,807	--	--	--	--

#### Table Descriptors:

- Goal:** To assure resources and services are provided to the DMH eligible population
- Target:** Maintain performance level of 95% of individuals being served by DMH community-based providers meet the DMH eligibility criteria.
- Population:** Adults with mental illnesses.
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** Percent of adults being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.
- Measure:** Numerator: Number of individuals being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.  
Denominator: Total number of individuals being served by DMH-funded community-based providers.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** State mental health resources and services should be provided to the priority populations of the public mental health system.
- Action Plan:** DMH aims to maintain or increase the proportion of persons served who meet the established criteria for “eligible population” at the time of entry into services.

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Employment

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	20.50	20.73	20.50	20.50	N/A	N/A
Numerator	26,491	29,406	--	--	--	--
Denominator	129,524	141,807	--	--	--	--

Table Descriptors:

<b>Goal:</b>	Continue tracking employment status of consumers at case opening
<b>Target:</b>	Track number of individuals employed at case opening
<b>Population:</b>	Adults with mental illnesses
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of adults engaged in full or part time employment that is unsubsidized at case opening
<b>Measure:</b>	Numerator: Number of adults reported as employed full or part time in unsubsidized employment at case opening Denominator: Total number of adults receiving services within the fiscal year.
<b>Sources of Information:</b>	Reporting of Community Services System (ROCS)
<b>Special Issues:</b>	
<b>Significance:</b>	Employment is a key issue relating to recovery and resilience. In FY 2007, employment rates were slightly above 20% at point of intake. This descriptive data, collected before services are initiated, is not expected to change. These low levels are consistent with national findings and indicate the importance of further developing employment and supported employment services. DMH plans to continue tracking this data while developing specialized employment services.
<b>Action Plan:</b>	

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Forensic Outpatient

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1.70	1.83	1.80	1.80	N/A	N/A
Numerator	2,244	2,597	--	--	--	--
Denominator	129,564	141,807	--	--	--	--

Table Descriptors:

- Goal:** To track forensic status of adult clients served by the Mental Health system.
- Target:** Track the forensic status of consumers accessing mental health treatment through the Reporting of Community Services (RoCS) data collection system.
- Population:** Adults with mental illnesses.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adult clients who were court ordered into treatment due to a finding of Not Guilty by Reason of Insanity (NGRI) or Unfit to Stand Trial (UST) by criminal court at the time of case opening.
- Measure:** Numerator: Number of adults reported as unfit to stand trial, not guilty by reason of insanity or court ordered into treatment at the time of case opening.  
Denominator: Total number of adults served in the fiscal year.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** Community mental health staff track forensic outpatient status at the time of case opening. Slightly over 1% of persons with mental illness are forensic outpatients.
- Action Plan:** DMH plans to continue tracking forensic outpatient information at intake. DMH efforts to link mental health databases with county jails are ongoing and provide another means of identifying persons with current involvement in the criminal justice system, as well as facilitating service provision. (See objectives A1.10 to A1.15, Section III-A)

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** HISTORY OF INVOLVEMENT WITH THE CRIMINAL JUSTICE SYSTEM

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	2.30	2.27	2.30	2.30	N/A	N/A
Numerator	2,872	3,215	--	--	--	--
Denominator	129,564	141,807	--	--	--	--

Table Descriptors:

- Goal:** To track forensic status of adult clients served by the Illinois Mental Health system.
- Target:** Track the forensic status of consumers accessing mental health services.
- Population:** Adults with mental illnesses.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adult consumers reporting involvement with the Justice System at the time of case opening.
- Measure:** Numerator: Number of adults reported as involved with the justice system (e.g. probation, parole) at the time of case opening.  
Denominator: Total number of adults served in the fiscal year.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** Identifying individuals experiencing involvement with the justice system at time of case opening can increase coordination of services between the mental health and justice systems.
- Action Plan:** DMH plans to continue tracking justice system involvement information at intake. DMH efforts to link mental health databases with county jails are ongoing and provide another means of identifying persons with current involvement in the criminal justice system, as well as facilitating service provision and coordination.

## ADULT - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Living Independently

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	65.10	79	79	79	N/A	N/A
Numerator	84,379	112,380	--	--	--	--
Denominator	129,564	141,807	--	--	--	--

Table Descriptors:

- Goal:** To track demographic information on living arrangements of adult clients.
- Target:** Track number of individuals living independently at case opening. No increase is projected as this data is collected at intake prior to treatment.
- Population:** Adults with mental illness.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of adults living in private residences\*, unsupervised, and considered to be living independently at the time of case opening.
- Measure:** Numerator: Number of adults living in private residence, unsupervised, and considered to be living independently at the time of case opening.  
Denominator: Total number of adults served in the fiscal year.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** The proportion of individuals reported as living independently at intake has increased from about 63% to nearly 80% over the past several years. This demonstrates the need for ongoing attention to housing services for individuals with mental illnesses. The increase in consumers who indicate living arrangements of private residence and unsupervised means that targeting of resources to persons with serious mental illness who have the greatest need for housing supports can become more precise.
- Action Plan:** DMH will continue to assess living arrangements at intake as a means of having baseline data on this indicator regarding the individuals who access DMH funded services.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

### **Name of Performance Indicator: RURAL RESIDENTS SERVED - ADULTS**

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	30,607	34,807	35,000	35,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

#### Table Descriptors:

- Goal:** To assure that individuals with mental illnesses who reside in rural areas are accessing the DMH-funded community-based mental health service system.
- Target:** DMH has set a target of identifying and providing services to 35,000 persons with mental illness in rural areas of the state.
- Population:** Adults with mental illness.
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** Number of individuals being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
- Measure:** Number of individuals reported by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** The geography of rural areas adds challenges to the timely and consistent access to services for both service providers and persons with mental illness.
- Action Plan:** DMH aims to expand access to community mental health services for persons residing in rural areas.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

### **Name of Performance Indicator: TARGET POPULATION - ADULTS**

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	56.60	56.40	60	62	N/A	N/A
Numerator	73,323	80,060	--	--	--	--
Denominator	129,564	141,807	--	--	--	--

#### Table Descriptors:

- Goal:** To assure resources and services are provided to the priority population of the publicly funded mental health system.
- Target:** Increase service level for persons with severe mental illness receiving mental health services in the publicly funded mental health system.
- Population:** Adults with serious mental illnesses.
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
- Measure:** Numerator: Number of adults being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.  
Denominator: All adults being served by DMH-funded community-based providers.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** The target group of adults with serious mental illnesses (SMI) is the priority population for the delivery of community mental health services.
- Action Plan:** DMH will continue to monitor service provision to assure that individuals with severe mental illness receive priority services.

## **ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Vocational Placement

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	3	2.67	3	3	N/A	N/A
Numerator	3,880	3,791	--	--	--	--
Denominator	129,564	141,807	--	--	--	--

Table Descriptors:

<b>Goal:</b>	To track demographic information on vocational placement for adult consumers.
<b>Target:</b>	Target will remain at 3%.
<b>Population:</b>	Adults with mental illnesses.
<b>Criterion:</b>	1:Comprehensive Community-Based Mental Health Service Systems
<b>Indicator:</b>	Percentage of adults who have a vocational placement at the time of case opening.
<b>Measure:</b>	Numerator: Number of adults reported as having a vocational placement at case opening Denominator: Total number of adults served in the fiscal year.
<b>Sources of Information:</b>	Reporting of Community Services (RoCS).
<b>Special Issues:</b>	
<b>Significance:</b>	Employment is a key issue relating to recovery and resilience. At intake in FY 2007, vocational placement levels were at slightly less than 3%. This descriptive data collected at intake – before services are initiated – is not expected to change over time. These low levels are consistent with National findings and indicate the importance of further developing employment services.
<b>Action Plan:</b>	DMH plans to continue tracking this data while developing specialized employment services.

# Illinois

## Child - Establishment of System of Care

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

## **CHILD AND ADOLESCENT (C&A) PLAN**

### **SECTION III-A: OBJECTIVES FOR FY2009**

#### **Criterion 1. Comprehensive Community-based Mental Health System**

##### **Overview and Organization of the Comprehensive System.**

**See Section II for a description of Child and Adolescent Services at the state level including central office structure.**

##### **Family Participation**

The participation of parents/caregivers and adolescents in planning and evaluating the quality of mental health services is an important aspect of the Illinois public mental health system. DMH has maintained this effort as a priority during FY2008. Activities directed toward increasing family voice and participation in the provision of C&A services statewide and in DMH Regions will continue in FY 2009. DMH continues to:

- Support the establishment of Family Resource Developers within Screening Assessment and Support Services (SASS) programs.
- Hire Family Consumer Specialists as C & A staff members of DMH in each region of the state. Four new full time positions were added statewide in FY2008 and one is to be added in Region V, so that by the end of FY2009, each of the five DMH regions will have a Family Consumer Specialist available.
- Require that Family Resource Developers are members of the Community Support Team when these teams are providing services to youth and their families.
- Increase family participation in Regional Planning Councils, and the MHPAC. In FY 2008 the leadership of the Child and Adolescent sub-committee of the Illinois Mental Health Planning and Advisory Council has been successfully filled by a parent and a community mental health director as co-chairs. This committee has become increasingly influential within the IMHPAC.
- Increase parent- to-parent support in the Mental Health Juvenile Justice Initiative.
- Assist and partner with the parent-led support group that is concerned with the enhancement of the quality of services in the Individual Care Grant (ICG) program through the provision of technical assistance. The ICG parent group continues to be a robust voice in the development of child services in Illinois. DMH staff continue to play a supportive role in the operation of this parent group.

##### ***Family Resource Developers***

DMH requires Family Resource Developers (FRDs) to be hired in SASS agencies. Increasing value has been placed on the expertise FRDs bring to the SASS teams. Of the 43 agencies providing SASS services, only three of the agencies have never hired a FRD. There is generally a modest level of turnover in the FRD staff, and at the point that the FY 2008 FRD survey was conducted, of 43 reporting agencies, 84% had FRDs

employed. The 84% statistic has remained consistent over the past two fiscal years and likely represents a reasonable turn-over rate of approximately 16%.

Monthly meetings are held for the FRDs in order to provide education, resource development and support for the positions. FRDs from the federally funded Systems of Care demonstration grants also attend these meetings. Each System of Care site has emphasized the importance and hiring of FRDs. While the survey results could not specify the number of FRD positions that were FY 2008 new hires, it was noted that their support role has expanded as some agencies are using FRDs to assist with Individual Care Grant application processes and service planning. Other agencies have hired more than one FRD into their agency as they continue to recognize the value of the position.

**Objective C1.1. Continue to work with parents and parent-led organizations to facilitate parent-to-parent support through the use of FRDs and work with parent and parent led organization to encourage substantive feedback on enhancing the quality of services at all levels of care.**

**Indicators:**

- Number of FRDs hired by SASS programs to facilitate parent-to-parent support.
- Percentage of FRD positions filled in FY 2009.
- Number of FRD's hired in C & A programs other than SASS.
- Number of Family Consumer Specialists hired by DMH to provide family voice to the DMH system and to increase the extent to which the DMH service system is family driven.

***Teen Advisory Group***

The Teen Advisory Group consists of youth who are currently, or have previously, utilized C & A services. The group consists of six members who meet monthly. Meetings were held each month in FY2008 to provide feedback to the C & A network regarding quality of care and youth perception of service need. Members of the group are compensated for each meeting they attend. During FY2008, the group has been working on developing youth leadership skills following the graduation of several experienced committee members in FY2008. The youth have been developing a project involving the impact of the media on mental health, and assessing the way mental health issues are portrayed in various media outlets. This objective will continue in FY2009.

**Objective C1.2. Continue efforts to develop and enhance the role of the DMH C&A Teen Advisory Group.**

**Indicators:**

- Monthly meetings of the teen advisory group held in FY 2009.
- Documentation of Teen Advisory Group participation and input into the larger DMH arena.

## **Teen WRAP**

Training on WRAP for providers who work with teens through Child and Adolescent agencies and the Mental Health Juvenile Justice Initiative began in FY 2007. The WRAP curriculum was modified to address the needs of youth. There are three agencies piloting WRAP in Chicago, one in LaSalle, the forensic adolescent inpatient unit in Springfield, and a sixth agency in southeastern Illinois will be trained this year. Representatives of the pilot sites for Teen WRAP meet monthly via teleconference to review the status of this new and innovative project throughout the past year. This new adaptive program is has reportedly been well received with satisfactory results and appears to have a promising future.

## **Evidence-Informed and Evidence-Based Practices**

DMH has an evidence based practice subcommittee that is co-chaired by DMH staff and a leader of the Community Behavioral Healthcare Association, the trade organization of the mental health centers. This committee is comprised of a diverse membership; including parents, university professors, child advocacy organizations, community mental health agencies and DMH staff. Recognizing the extreme diversity of the population in Illinois and the narrow definition of specific EBP models, at the advice of the EBP committee the DMH C&A Statewide Office is actively promoting Evidence Informed Practice (EIP). Evidence Informed Practice is defined as “a collaborative effort by children, families and practitioners to identify and implement practices that are appropriate to the needs of the child and family, reflective of available research, and measured to ensure the selected practices lead to improved meaningful outcomes”.

A five-pronged strategy, adopted in FY2006, for moving Illinois forward in its use of Evidence-informed practice for children and adolescents is being pursued:

1. Educate C & A agency leadership on an Evidence Based Practice Paradigm.
2. Train providers in specific evidence-based treatments.
3. Develop partnerships between universities that train the C & A workforce and the community provider, agencies. Develop the ability of training institutions to teach evidence-based practice during the early training of practitioners.
4. Review the extent to which Illinois Division of Mental Health policy supports or impedes evidence based practices.
5. Provide education to consumers on evidence-based practice.

During FY 2008 a significant amount of progress has been achieved toward each of these strategies:

- A second cohort of a 12-month long EBP training began in November 2007. There are now 18 agencies statewide who have participated in this effort to infuse evidence based clinical skill sets into the provider community using empirically tested training methods.

- Three Masters level training programs across the state have begun to graduate students with certifications in evidence based child and adolescent services. This initiative will increase the ability of the workforce to provide evidence-based intervention to youth in Illinois in the long term.
- Illinois DMH is requiring C & A providers to participate in a web based outcomes analysis system effective on 7/1/09. This system will allow families, providers, supervisors, agency directors and the state mental health authority to access data which can be used to inform decisions regarding effectiveness of service, training needs of the system, and a description of the system as a whole. Clinicians will use the OHIO Scale and families and youth will complete the Columbia Impairment Scale on a quarterly basis. Training efforts have begun to orient the child serving agencies to effectively utilize these instruments and technologies.
- Consumer conferences for parents on evidence-based practices are scheduled, and education campaigns for families on the use of outcomes measures are being developed.
- In FY2008, seven training sessions have been offered statewide on the topics of evidence based engagement strategies, and use of outcomes instruments. Web based training was held utilizing a train – the – trainer model to orient staff to the web based system.
- Sixteen in-person training days were held to teach evidence based clinical skills to community mental health staff participating in the pilot series. Each agency will receive 24 supervision sessions.

The following objective will be a priority for FY 2009:

**Objective C1.3. Continue to advance the implementation of evidence-informed practices in the child and adolescent service system:**

- In FY09, explore the possibility of utilizing video based training methodologies in an effort to further disseminate the current training resources to the more rural areas of the state.
- Contract with a fourth training University in the southern area of the state to broaden the impact of the C & A EBP certification program outreach.
- Monitor the number of agencies who are utilizing the web-based outcomes analysis system and provide further technical assistance regarding the clinical utility of this system.

**Indicators:**

- Number of training sessions using the curriculum that are scheduled and held.
- An approved plan for the use of video-based training methodologies in rural areas or their actual demonstrated use by the end of FY2009.
- A contract and curriculum is established with a fourth university to provide certification at the graduate level.
- The number of agencies utilizing the web-based outcomes analysis system with technical assistance.

## **Individual Care Grants for Children with Mental Illness**

The DMH Individual Care Grant (ICG) Program provides funds for residential treatment or intensive community treatment for children and adolescents with serious emotional disturbances who meet the criteria of severe mental illness and impaired reality testing. The ICG program is family driven, meaning that families make the decision regarding whether they wish to utilize their grant for residential or community based services. These decisions are generally made with consultation from the mental health providers working with the family. Services provided include intensive, home-based support, treatment, and therapeutic stabilization services that allow the child to remain at home. The ICG program is unique in the sense that parents do not have to relinquish custody of their children to obtain these services.<sup>1</sup>

Community-based ICG services are coordinated through agencies funded to provide SASS services. Agency staff work with families to identify appropriate support services. Proposed service plans are submitted by SASS to the DMH ICG community-based services coordinator, who reviews them for clinical necessity, and approves plans for a period of no longer than six months. The SASS agency then serves as a fiscal agent by purchasing the services specified in the approved plan and monitoring their effectiveness in meeting the youth's clinical needs. ICG services are available across the state.

For some youth, the Community Based ICG program serves as an excellent "step down" transition from residential care, for others, the community-based services are effective in preventing the need for institutional placement. Community-based ICG services are also an effective transitional support for the movement from child and adolescent services to adult services. Considerable efforts have gone into providing up to twelve months of post ICG funding to facilitate transitional integration into the community and into the adult service system. The program offers a number of supports, including child support services, case coordination services, behavior management services, and therapeutic stabilization services. Collaborations have been developed between special recreation associations and community SASS programs to assist youth in developing supportive relationships and new behavior patterns in the community.

---

<sup>1</sup> Four categories of services are available to ICG recipients under the community-based model. These include:

**1. Therapeutic Stabilization** – “*An essential part of in-home services, providing a timely one-to one relationship between the child and a contractual agent of the SASS agency for the purpose of facilitating age-appropriate, normalizing activities of the child.*” This intervention allows for up to 21 hours per week of service per child. The number of hours approved must be justified by the level of the child’s functional impairment.

**2. Behavior Management Intervention** – “*A time-limited child and family training/therapy intervention focused toward amelioration or management of specific behaviors that jeopardize the child’s functioning in the home/family setting. This intervention typically teaches/models techniques and skills that can be used by the parent/guardian and other family members.*” This intervention is typically used to purchase expertise to support a child that requires expertise above and beyond that generally available in the local community mental health agency, an example would be the services of a dietician or fitness trainer to address the needs of a child who has gained a great deal of weight while taking psychotropic medications, or de-escalation training for parents.

**3. Child Support Services** – “*Time-limited funding to cover costs that would otherwise be prohibitive to the parents for the child to participate in community activities when those activities are related to objectives in the child’s current individual services plan.*” These services often include therapeutic recreation, music, art, after-school programs, or therapeutic summer camps.

**4. Young Adult Support Services** – “*Time-limited funding for young adults to cover costs of services and supports, to aid the young adult in his or her transition to community living.*” These services may include a young adult taking a class in a community college to teach money management or cooking skills.

The ICG program received 1,051 requests for applications in FY2007. Of the 303 applications returned to the ICG program for eligibility determination, the ICG program awarded 81 grants. The total number of children receiving ICG services in FY2007 was 570. As of June 30, 2007, there were 484 active ICG cases. One hundred fifty-three children and adolescents received community services under the ICG program. This represents 32% of ICG families. As of May 15, 2008, 187 youth had been served in community-based care out of the 496 youth in the program which represents 38% of the total population, and is consistent with the percent served in community based care in FY2007.

In FY2009 the program will have access to additional supports from the Mental Health Collaborative for Access and Choice (MHCAC) and access to recent research on the Illinois ICG population. These resources and data will be utilized to further strengthen the community ICG service system with the goal of increasing the percentage of youth who are safely cared for in community-based care.

**Objective C1.4. Continue to strengthen community service options in the DMH ICG program and increase the number of youth served.**

**Indicator:**

- Number of children served through ICG community service options in FY 2009.

**Public Awareness Campaign**

The Report of the President's New Freedom Commission on Mental Health noted that the "stigma that surrounds mental illnesses is one of three major obstacles preventing Americans with mental illnesses from getting the excellent care that they deserve". Funds totaling \$300,000 have been allocated to implement strategies geared toward reducing the stigma families and children experience when afflicted with serious emotional disturbances and mental disorders. *The DMH "Say It Out Loud" Campaign is directed to adults, children and families. For a description of the campaign, see Section I and the Adult Plan, Section III-A, this criterion.*

**Objective C1.5. In collaboration with the Children's Mental Health Partnership, continue to advance the public awareness campaign to reduce negative portrayals associated with mental illnesses. Expand the focus to greater access to mental health services and the interaction of mental health, the experience of violence, and applicable prevention/intervention efforts .**

**Indicators:**

- Number of focus groups or expert panels conducted by contractor to obtain information to evaluate and expand the campaign.
- Materials developed for dissemination that address resource and access issues.
- Materials developed for dissemination that address the interaction of mental health, mental illness, and violence.
- A report of the key achievements of the campaign and the significant public venues utilized to bring the message to all the citizens of Illinois.

### **C&A Performance Indicators**

Performance indicators are described in Section III-B. Operational definitions are provided, the use of the indicator is described, and the source of data that is used to compute indicator values is identified. Data is provided for FY 2005 through FY 2007, and projections have been made for FY 2008 and FY 2009. FY 2008 actual data will be provided in the FY 2008 Mental Health Block Grant Implementation Report.

<b>Key System Performance Indicators – Children and Adolescents</b>	
<b>Indicator Reference Number</b>	<b>Indicator Description</b>
<b>Criterion 1</b>	
C1.1	Percentage of children/adolescents living with parents or other relatives in a private residence
C1.2	Percentage of children/adolescents court ordered into outpatient treatment
C1.3	Percentage of children/adolescents reporting involvement with the juvenile justice system (Department of Corrections)
C1.4	Percentage of children/adolescents with serious emotional disturbances receiving case management services
C1.5	Percentage of service hours to children/adolescents receiving SASS services which occur in community settings outside of providers' offices or clinics.

# Illinois

## Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;  
Employment services;  
Housing services;  
Educational services;  
Substance abuse services;  
Medical and dental services;  
Support services;  
Services provided by local school systems under the Individuals with Disabilities Education Act;  
Case management services;  
Services for persons with co-occurring (substance abuse/mental health) disorders; and  
Other activities leading to reduction of hospitalization.

See Section II for description of available services and resources in a comprehensive system of care.

# Illinois

## Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

**Prevalence Estimate For Children and Adolescents**  
For an estimate of Children and Adolescents with Serious Emotional Disturbance, Illinois has used the 7% estimate provided in the CMHS notice in the Federal Register, Volume 63, Number 137, July 17, 1998 based on the average of the lower limit at a level of functioning of 50 (LOF=50) and the upper limit at a level of functioning (LOF=60). The figure has been updated by CMHS using 2007 census information to 112,868 or a 6% estimate for children and adolescents aged 9 to 17 based on a 14% (FY2006) poverty rate.

# Illinois

## Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

## **Progress In Performance Measurement for Children and Adolescents with SED**

See the Adult Plan Section II, Criterion II, for a discussion of progress in performance measurement and Illinois experience of collaboration with federal initiatives. This background is applicable to children's services as well as adults.

Child and Adolescent Outcomes Analysis: In FY2007, the DMH contracted with a web-based research company to develop a Web-based Clinical Outcomes Analysis system. The system was completed and training of users had begun by the end of FY2008. The system consists of four measures: (1) The OHIO Scale-Worker version; (2) The Columbia Impairment Scale for Parents; (3) The Columbia Impairment Scale for Youth; and (4) Goal Attainment Scaling methodology (optional). The instruments are used at case opening, quarterly thereafter, and at closing. Users of the web-based system will be able to generate immediate feedback reports at each level of service. Clinicians will be able to generate reports and graphic profiles on their individual clients across specified time periods which are shared with the client and family. Access to this data is a valuable benefit to the client and family as a means of being able to see, use, and share an objective assessment of progress and accomplishments as well as identification of issues to work on. A term coined to describe this aspect is "refrigerator art"- something posted in a common place for all the family to see. Agency site coordinators of the system will be able to generate agency wide service reports. DMH will be able to compile system-wide data from all the participating agencies. Providers have been trained during FY2008. The system is currently being initiated and all child-serving agencies under contract with the Division of Mental Health are required to participate.

**Objective C2.1: By the end of FY2009, all DMH funded child serving agencies will be able to participate in the web-based Clinical Outcomes Analysis system and initial reports showing data trends in service outcomes will be produced and disseminated.**

### **Indicators:**

- Number of agencies participating by the end of FY2009.
- A system-wide data report will be generated, approved and disseminated.

## **Access to Services- Quantitative Targets For FY2008**

### **DMH Target Population**

In FY 2005, the percentage of children and adolescents meeting the DMH target population criteria was 30.4%and increased slightly in FY 2006 to 32%. In FY2007 the percentage increased again to 33.4%. Data for FY2008 will be provided in the Implementation Report. Since FY2005, the data for this indicator has likely been an underestimate due to the fact that the DMH still has no access to SASS data.

**Performance Indicator C2.1: Increased Access to Services by the DMH Child/Adolescent Target Population**

### **Indicator:**

- Percentage of the DMH C&A target population receiving services.

## **DMH Eligible Population**

In FY2005, the percentage of children and adolescents meeting the DMH eligible population criteria was 89.5% and decreased to 86.5% in FY 2006. In FY2007, it rose to 88.2%. FY2008 data will be provided in the Implementation Report. Since FY2005 the data for this indicator is likely an underestimate due to the fact that the DMH still has no access to SASS data.

### **Performance Indicator C2.2: Increased Access to Services by the DMH Eligible C&A Population Indicator:**

- Percentage of the DMH C&A eligible population receiving services

### **C&A Performance Indicators – Criterion 2**

These performance indicators are described in detail in Section III-B.

<b><i>Criterion 2</i></b>	
C2.1	Target Population - C & A: Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
C2.2	Eligible Population – C&A: Percent of individuals being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.

# Illinois

## Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;  
Educational services, including services provided under the Individuals with Disabilities Education Act;  
Juvenile justice services;  
Substance abuse services; and

Health and mental health services.

### **Criterion 3. Children's Services**

#### **Inter-Agency Collaboration – Child Serving Systems**

DMH staff continues to work in collaboration with other State departments, IDHS Divisions and private service providers to improve services to children and adolescents with severe emotional disturbance and other human service needs. These collaborations include the following:

**DMH and DCFS.** The focus of this collaboration is transition services for youth moving from child welfare services to adult mental health services.

**DMH and the Children's Mental Health Partnership** – DMH and the Children's Mental Health Partnership are collaborating on early intervention pilot projects, and on transition Services for youth with SED.

**DMH and DASA** – The focus of this collaboration is on infrastructure building to provide services for Children and Adolescents with co-occurring mental health and substance abuse problems.

**DMH and ISBE-** A Federal Department of Education Grant was awarded to increase the integration of school mental health services and community mental health centers.

Many local collaborations exist such as the collaboration of the McHenry County 708 Board and the University of Illinois - Rockford on the new SAMHSA System of Care grant described previously in this application. Other collaborations are described in Sections I and II .

#### **Wraparound Services**

The Wraparound service approach continues to be essential to the provision of case management services for children. These services, which are provided to families, offer traditional and non-traditional supports by using the local network of community providers and associations. In this approach, there is a definable planning process involving the child and family, which results in an individualized plan which focuses on strengths and needs across multiple settings. The DMH provides funds to SASS programs throughout the state to support wraparound services. Although maintenance of funding for Wraparound Services will remain a priority in FY2009, performance data is not available as SASS data is no longer reported directly to the DMH.

#### **Services for Dually Diagnosed (MISA) Youth**

DMH Regional C & A staff in collaboration with the DHS Division of Alcoholism and Substance Abuse (DASA) are continuing to explore staff training needs and to assess program capacity requirements for addressing the clinical needs of this population.

DMH Child and Adolescent Services continues to collaborate with the DASA staff on a grant to build infrastructure to serve children and adolescents with co-occurring mental health and substance abuse issues. This collaboration identifies and addresses

opportunities to collaborate on the infrastructure building, cross training, parent and consumer involvement and funding.

DMH routinely monitors the percentage of youth reported as having a co-occurring substance abuse and mental health disorder. ***System Performance Indicator C3.6 tracks the number of MISA clients in the service population.***

### **Mental Health and the School System - System of Care- Chicago**

In FY2003, the DMH Metro C&A Network applied for and received an award from SAMHSA for \$9.5 million for a period of six years to develop comprehensive community mental health services for children and their families. FY2008 was the sixth year of this grant that is ending in September 2008. The primary goal of this federally funded initiative is to promote the development of a system of care involving all child-serving systems and partnerships in the Chicago area. At the service delivery level, collaboration has been fostered through the implementation of the Positive Behavioral Interventions and Supports (PBIS) model as it has been adapted to the Chicago-PBIS model. Staff from mental health agencies participating in the project have actively partnered with staff of the seven participating schools to support the PBIS model that is universal (school-wide), targeted (special populations) and intensive (identified children and youth with serious emotional disturbance needing individualized supports) within the school setting. The SOCC Initiative has met the majority of its established goals. As a result of the successful collaboration, the Chicago Public Schools was awarded a 4-Year, \$8 million Safe Schools-Healthy Students Grant from the U.S. Department of Education to support the integration of school mental health services and community mental health centers. The System of Care collaborative effort, including its key participants, are continuing under the direction of the Chicago Public schools with funding from this grant. Progress on the continuing objective for the system of Care will be reported in the FY2008 Implementation Report. There is no objective for FY2009 as the grant has ended. Additionally, McHenry County received an award from SAMHSA in 2004 to expand System of Care principles and practices in that county. See Section II, Criterion 3.

### **Mental Health and Juvenile Justice**

Research has demonstrated that the majority of juveniles in detention centers meet the criteria for a psychiatric diagnosis and one in six has a serious mental illness. Many of those also have a co-morbid substance abuse disorder (Teplin, et al. 2005). The juvenile justice system frequently either fails to identify these youth or fails to provide the necessary mental health treatment. The Mental Health Juvenile Justice (MHJJ) program was conceived and implemented to address this critical need. MHJJ provides an alternative to incarceration for juvenile detainees with serious mental illnesses, by arranging for the necessary mental health services to address individual clinical needs. Initiated as a pilot project in 2000 in just seven counties, MHJJ has expanded to each of the 17 Illinois counties with a detention center and one county without a detention center. This year, the program added additional staff in the southern region to provide services to additional counties. In addition, two additional community agencies were added to the program in Cook County to provide further outreach and service linkage to the Latino

community. The program has expanded to 21 community agencies and over 60 MHJJ program staff.

MHJJ liaisons screen the youth for the presence of serious mental illness. For the purposes of this program, serious mental illness is defined as a psychotic or affective disorder. Once found eligible, youth are enrolled in the program and are linked with appropriate community-based treatments consistent with their current clinical needs and individual strengths. After being linked to services, MHJJ liaisons continue to provide case management services and monitor progress for a period of six months.

The data for the FY 2007 indicators and the Year-to-date data for FY2008 are detailed below. Complete FY '08 data will be available later this year.

FY'07	= 1249 referred = 867 screened = 747 eligible = 682 enrolled	FY '07 = 81.2% linked to services FY '07 = 21.3% re-arrest rate
FY'08 (thru April 08)	= 1170 referred = 587 screened = 549 eligible = 485 enrolled	FY '08 = 77.0% linked to services FY '08 = 23.2% re-arrest rate

In FY 2007, minority enrollment surpassed that of Caucasian enrollment for the first time in the history of the MHJJ program. This is a significant finding in light of data for previous years which identified disproportionate minority contact associated with MHJJ services.

In FY2009, the MHJJ program will continue to identify and screen juvenile detainees with serious mental illnesses and link them with appropriate community-based services. An evaluation of the MHJJ program has found that these services result in overall clinical improvement, decreased functional impairment, and reduced rates of recidivism for youths enrolled in the program.

The following additional initiatives will be undertaken by the program in FY2009:

1. Increase the number of minority youths referred to the MHJJ program. The program continues its efforts to identify minority youth with serious mental illnesses and link them with the appropriate community-based clinical services. Both the percentage of minority youth referred (51.7%) and the percentage of minority youth enrolled (53.9%) increased this fiscal year. This will continue to be a priority objective for the program particularly in light of the overrepresentation of minority youth in the juvenile justice system.

2. Since the number of service sessions is associated with positive outcomes maintaining and increasing the number of service sessions offered will continue to be a priority. Data on the average number of service sessions for the current fiscal year is not yet available. However, given the strong correlation with improved clinical and functional outcomes this merits continues monitoring and analysis.
3. Increase clinical services most strongly associated with positive outcomes which are: Individual therapy, school consultation, psychiatric hospitalization, psychiatric medication and case management services. In FY2008, 65% of youth enrolled received individual psychotherapy, 23.25% received school consultation, 7.3% were psychiatrically hospitalized and 33.2% were receiving psychiatric medications. Historically, case management services are most strongly correlated with improved outcomes, though the percentage of youth receiving this service continues to decline (from 44.2% in FY06 to 37.3% in FY '08). The reasons for this decline remain unclear and will be the focus of further evaluation.

**Objective C3.1. In FY2009, increase the number of youth receiving services through the Mental Health Juvenile Justice Initiative (MHJJ)**

**Indicators:**

- Number of youth served by the program statewide.
- Number linked to services, and
- Number of youth re-arrested

**Other DMH Child and Adolescent Initiatives - FY 2009**

**Illinois Children's Mental Health Partnership (ICMHP)**

***Social Emotional Learning***

As reported previously, the DMH has a relationship with the Children's Mental Health Partnership that continued its on-going collaborative efforts in FY2008. The Illinois Children's Mental Health Partnership (ICMHP) was established in FY 2003 and charged with developing a comprehensive, multi-year Children's Mental Health Plan. The plan that was developed included requirements for the Illinois State Board of Education (ISBE) to incorporate social and emotional development standards as part of the Illinois Learning Standards. The ISBE and ICMHP partnered with the Collaborative for Academic, Social and Emotional Learning (CASEL) and a team of twenty five educators to develop 10 standards aligned with the following three goals: (1) students should develop self-awareness and self-management skills, (2) students should develop social awareness and interpersonal skills and (3) students should demonstrate decision making skills and responsible behavior. One hundred developmentally appropriate benchmarks and 600 performance descriptors are now posted on the ISBE web site. This partnership effort was supported by small grants to school districts to offset the costs of enhancing mental health services in schools and implementing a Statewide Professional Development Plan to support leadership teams for schools as they draft SEL implementation plans.

### ***Initiatives Supported and Funded Through ICMHP***

In addition to this school-based approach, the ICMHP has been successful in garnering state funds for children's mental health needs. The DMH Child and Adolescent Office works closely with the ICMHP in planning how the funds are to be used and implementing those plans. ICMHP obtained a \$6.5 million budget in FY2008 which allowed for expansion of three key projects already undertaken by DMH and the partnership in FY2007.

### **Transitional Services**

DMH accomplished its goal to expand mental health transition services to youth. During FY2008, DMH, in collaboration with ICMHP, offered a Request for Service Plans (RSP), to solicit proposals to develop and provide mental health services that address the unique and special needs of older adolescents (16-17 years old) with SED who are transitioning from C&A services to adult services and for any youth with SED who is transitioning from correctional services to the community. DMH awarded \$100,000 to one successful bidder in each of the five DHS regions. Implementation of FY 2008 grant awards paired with the five (5) pilot projects introduced in FY2007 resulted in a total of ten (10) pilot sites and \$1,000,000 in statewide funding. In addition to providing an array of mental health services all projects are expected to build community infrastructure that will facilitate and support expansion of transition services for youth and the effectiveness of services, as well as development of a system of care for transitioning youth. To date, 257 consumers have received transition services and 4,227 direct service hours. The outcomes of these programs will provide vital information as to the service models and intervention strategies that work best for the target population groups addressed by DMH's Mental Health Transition Services for Youth initiative.

**Objective C3.2:** During FY 2009, continue to monitor and evaluate each site with special emphasis on: determination of appropriate utilization rates and service outcomes; identification of effective intervention strategies; and identification of regional similarities or differences relevant to service need and delivery.

#### **Indicators:**

- Total number of transitioning youth served at each site.
- Total amount of services reported and Medicaid billed to DMH's electronic data reporting system.
- Provider documentation of outcomes, lessons learned, gaps and challenges in the service system, networking, and successful or promising service delivery strategies and/or innovations.
- Number of meetings held with all the providers to share experiences and solutions to problematic issues.

### **Early Intervention**

The Early Intervention Initiative is a granting opportunity to agencies with the aim of identifying children at risk, especially those at risk of depression, and to intervene early.

Case finding needs to go on in venues outside the normal service paths for children with serious disturbances. In FY2007, \$500,000 was awarded to five agencies. One agency in each of the five regions was selected by an open and competitive Request For Proposal (RFP) process to receive a \$100,000 award to provide early intervention services. Flexibility was emphasized as each agency developed its own plan and approach to early intervention based on the unique geographic, cultural, and interagency service environments in each region. In FY2008, another five agencies were funded in the same way so that two agencies in every region are now in a position to coordinate early intervention services.

During FY2008 DMH, in collaboration with ICMHP, offered a Request for Service Plans (RSP), to solicit proposals to develop and provide Mental Health Early Intervention Services for Children and Adolescents and awarded \$100,000 to one successful bidder in each of the five DHS regions. Implementation of FY 2008 grant awards paired with the five- (5) pilot projects introduced in FY 2007 resulted in a total of ten (10) pilot sites and \$1,000,000 in statewide funding. A major goal of this initiative is to identify and engage children and adolescents with mental illness or social/emotional problems who are untreated, and those at risk of serious emotional disturbance or social/emotional problems. The overall objectives of this initiative are to implement a statewide system of early intervention services and to develop a network of providers who will be able to identify best practice models through their experience.

To date 232 children and adolescents, and their families have received early intervention services and 4,814 direct service hours.

**Objective C3.3: In FY 2009, continue to monitor and evaluate each site with special emphasis on: determination of appropriate utilization rates and service outcomes; identification of effective intervention strategies; identification of regional similarities or differences relevant to service need and delivery; and identification of opportunities for additional expansion of the initiative to more providers and communities.**

**Indicators:**

- Total number of children and families served by the end of the fiscal year.
- Total amount of services reported and Medicaid billed to DMH's electronic data reporting system.
- Provider written reports that document outcomes, lessons learned, gaps and challenges in the service system, and networking outcomes.
- Provider documentation of successful or promising service delivery strategies, innovations and/or service models.
- An initial report documenting outcomes, lessons being learned, gaps and challenges in the service structure, and successful innovations in early intervention services to children and families is drafted, reviewed, approved, and disseminated.

### **Early Childhood Mental Health :**

The Early Childhood Mental Health Program was established during FY2008. DMH Child and Adolescent Services and the Illinois Children's Mental Health Partnership (ICMHP) identified early childhood mental health as a priority in Illinois. An outcome of identifying that priority was both entities collaborating to release a Request for Service Plan (RSP) that invited applications to provide an array of developmentally appropriate mental health services to children ages 0-5 who are experiencing mental health and/or social/emotional development problems. Successful RSP applicants each received a \$70,000 grant for one-half fiscal year, January 1, 2008 to June 30, 2008, with a possible grant renewal for the entire FY2009 of \$100,000. Five (5) child-serving mental health providers were funded to: a) provide mental health assessment and treatment services to children age 0 – 5 years with psychological or social/emotional development needs; b) provide parent support services to families of eligible children; c) provide services that are child focused and family driven; and d) develop connections to referral systems/networks for early childhood.

**Objective C 3.4: During FY 2009, through monitoring and program evaluation determine whether each funded program achieved the service and system development requirements of their grant and collaborate with providers to delineate program outcomes, identify unmet needs, identify strategies to address needs and gaps in each service region, and develop recommendations for evidence informed and best practice models in early childhood mental health that Illinois should consider implementing.**

#### **Indicators:**

- The number of children ages 0-5 served in FY2009.
- A description of services provided to children and their families/caretakers and the number of service hours provided for each service in FY2009.
- Number of meetings convened with participating providers to share information on best practices, program outcomes, unmet needs, and strategies to address service gaps and needs.

In support of this program, an Early Childhood Consultation program was expanded statewide in FY2008. This program began as a joint venture of the Illinois Children's Mental Health Partnership and Michael Reese Hospital's Early Childhood program. The consultation and treatment program was very successful in Chicago but Michael Reese's funds were limited to Chicago. The Illinois Children's Mental Health Partnership obtained sufficient funds to extend the program to seven agencies in the state in FY2007. A total of \$500,000 was budgeted to cover 10-12 agencies in FY2008. Consultants are paid to travel to the selected agencies and provide case consultation, education in early childhood issues, and training to selected agency staff for a period 12-18 months. Agencies successfully completing the training and consultation program will receive funds to expand their services and provide support to other agencies in their area that are developing this specialization.

This project is currently administered by ICMHP and was expanded during FY2008. During FY2009, DMH C&A staff will work with the Illinois Children's Mental Health Partnership in a collaborative relationship to identify the parameters relevant to early childhood consultation. Included in this effort will be: definition of service expectations, delineation of the early childhood consultation outcomes, review of the evaluation data from currently and previously funded Early Childhood Mental Health Consultation providers, an assessment of the overall impact of the program, identification of unmet needs, and identification of strategies to address needs and gaps. DMH C&A Services will continue to prioritize the further expansion of services to this age group and evaluation of the process.

### **C&A Performance Indicators – Criterion 3**

These performance indicators are described in detail in Section III-B.

<b>Criterion 3</b>	
C3.1 (NOM)	Percentage Of Caregivers Reporting Positive Outcomes Of Treatment For Children/Adolescents Receiving Services.
C3.2 (NOM)	Decreased rate of civil readmissions to state psychiatric hospitals within thirty days of being discharged from a state hospital.
C3.3 (NOM)	Decreased rate of civil readmissions to state psychiatric hospitals within 180 days of being discharged from a state hospital.
C3.4 (NOM)	Number Of Children/Adolescents Served by Gender, Race/Ethnicity, and Age.
C3.5 (NOM)	Use of Evidence-Based Practices
C3.6	Number of Child and Adolescents (C&A) served with a MISA based diagnostic category*.
C3.7 (NOM)	Percent of Parents Reporting an Improvement in Child's School Attendance
C3.8 (NOM)	Percent of children/adolescents arrested in year 1 who were not arrested in year 2
C3.9 (NOM)	Percent of children/adolescents in are homeless or living in shelters
C3.10 (NOM)	Percent of caregivers reporting positively about Social Connectedness
C3.11 (NOM)	Percent of caregivers reporting positively about Improved Level of Functioning



# Illinois

## Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Overview and Organization of the Comprehensive System.  
See Section II Child Plan for a description of Child and Adolescent Services at  
the state level including central office structure. Section II also contains  
the defined geographic service area.

# Illinois

## Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

### **The Homeless Population in Illinois**

**See Adult Plan, Section II and C&A Plan Section II, this criterion, for descriptions of the EF&S Program, the Annual Report, and its implications.**

The Annual Emergency Food & Shelter Report noted that in FY 2007, 6,500 households with children accounted for 13,224 participants under the age of 18 (29% of the total served) of which 50% (6,569) ranged from newborn infants through five years of age. Combined with the 18 through 21 year old group (2,697) nearly 33.4% of the homeless persons served by the EF&S program were under the age of 22.

### **Outreach To Homeless Youth**

#### **Providing Mental Health Services to Homeless Youth**

The DMH continues to provide funding to maintain and enhance services to homeless youth. System Performance Indicator C4.1 was created in FY 1999 to track the number of homeless youth entering community-based services in the public mental health service system. This system performance indicator permits an initial evaluation of the system's ability to provide access to mental health services for runaway youth and children in families who are homeless and who have serious emotional disturbances. In FY 2005, 401 youth were identified as undomiciled or homeless at their initial assessment; this number decreased in FY 2006, with 365 and decreased again in FY2007 when 300 youth were reported as homeless. **See C&A Plan, Section II, this criterion, for descriptions of programs that provide outreach services.**

# Illinois

## Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

### **Mental Health Services to Youth Residing in Rural Areas**

DMH continues to focus on increasing access to child psychiatry for children/adolescents residing in rural areas. We continue to track the number of rural youth served (**see System Performance Indicator C4.2**) in the public mental health. The C&A population of the 76 Illinois counties designated as rural was 471,894 according to 2000 census figures, yielding a mental health prevalence estimate of 33,032 (at 7%). In FY 1999, 9,294 individuals under 18 years old who live in the above 76 rural counties received DMH funded services. There appears to be a trend toward increased access of services by this population as 9,744 youth received services in FY2004, 10,247 youth received services in FY2005, 11,014 in FY2006 and 11,590 in FY2007.

### **Child Psychiatry Consultation Program**

DMH Central and Southern regional staff have worked closely with community providers to enhance child expertise and to reconfigure SASS (Screening, Assessment and Support Services) to meet the needs of children and adolescents residing in rural areas. The reconfiguration of services has focused on the provision of services by providers closely tied to these communities, and the use of a consultative model to ensure that a Child Psychiatrist is available to the community psychiatrist when no child psychiatric services are available. Two strategies have been undertaken to address the shortage of child psychiatrists: (1) Both Regions have applied for designation as professional shortage areas for child psychiatry and (2) The statewide DMH Deputy Director for child and adolescent services, who is a Child Psychiatrist, has been working with the American Academy of Child Psychiatry to recruit board eligible child psychiatrists to provide services in these regions.

Providing consultative services to local program staff has provided an innovative vehicle for supporting the delivery of services in the state's foremost rural regions while efforts to recruit psychiatric staff are underway. The Child and Adolescent Training Institute at the University of Illinois in Chicago implemented a program of child psychiatry consultation through the use of video-conferencing. This program, which began in March of 2002, matched three child and adolescent psychiatrists from urban areas to three rural community mental health centers that have very limited access to child and adolescent psychiatrists. Over the course of several years, child psychiatrists at the University of Illinois have performed many psychiatric consultations. This program has been highly valued by participating community mental health centers.

In FY2008, DMH budgeted approximately \$300,000 for a pilot project which allows six agencies to each purchase \$50,000 of qualified psychiatric consultation time to be provided through a Tele-Psychiatry approach ranging from informal case discussions to formal case reviews, and a telemedicine approach in which the child is present for assessment. The telepsychiatry initiative was established in Regions 4 and 5. The project was awarded in February, 2008 to Aunt Martha's Youth Services as the vendor. Services include assessment, treatment and ongoing monitoring of youth. A competitive RSP was sent to agencies in the two regions. Region 4 developed a collaboration among four agencies, so there are seven agencies involved in the two regions. The equipment was purchased and the t1 lines were installed. Actual services began July 2008.

**Objective C4.1:** Implement a telepsychiatry pilot project in seven rural sites in Illinois. Establish baseline for service utilization and assess the need for further enhancement and expansion in FY2010.

**Indicator:**

- Number of youth served FY2009
- Number of psychiatry hours provided in FY2009.

**C&A Performance Indicators – Criterion IV**

The performance indicators below are described in detail in Section III-B.

<b>Criterion 4</b>	
C4.1	Number of children being served by DMH-funded community-based providers who are reported as undomiciled or homeless at the time of entry into services.
C4.2	Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.

# Illinois

## Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

The DHS Division of Mental Health continues to work towards an integrated system of care that includes both state hospitals and community-based providers, including those that are responsible for emergency health services regarding mental health.

### **Enhancing Financial Resources**

See Section II, Criterion 5 of the Adult Plan for a discussion of this topic which is applicable to both adults and children.

#### ***Increasing Financial Resources For The Child And Adolescent Population***

The DMH and its partners have been successful in increasing financial resources to provide/purchase services for children and adolescents and their families through several sources. For example, the System of Care Chicago grant that has brought major new funds targeting the child and adolescent population into the state. This grant, which was funded at \$9.5 million over a six year period has ended. The system of care grant awarded by SAMHSA CMHS to McHenry County in FY 2005 was also funded at \$9 million dollars per year over a six year period. The McHenry SOCC will continue through FY 2011. In FY 2008, \$6.5 million dollars has been allocated for mental health services for children and adolescents through a partnership with the Illinois Children's Mental Health Partnership.

#### ***Increasing Federal Financial Participation (FFP)***

***This section is applicable to both adults and children. It is available in the Adult Plan, Section III-A, Criterion 5. Objective A5.1/C5.1 of the Adult Plan covers adults and children.***

# Illinois

## Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

## **Enhancing Human Resources**

Human resource development is critical in terms of supporting community-based services for adults with serious mental illness and children with serious emotional disturbance and their families.

### **Activities Related to Human Resource Development**

The DMH has contracted with the University of Illinois at Chicago Department of Psychiatry to oversee the implementation of a Statewide Child and Adolescent Training Initiative. Three training modules have been presented at seven locations in the State with over 2000 attendees. Two significant outcomes have resulted: (1) telepsychiatry consultation has been introduced in some of the states rural areas (See Criterion 4) and (2) work with community mental-health trade organizations and the University of Illinois at Chicago on the development of a curriculum geared towards the needs of persons with Bachelors and Masters degrees was completed. The curriculum was promoted and marketed to both the academic and provider communities. The DMH Statewide C&A staff continue to collaborate with the University of Illinois on these efforts as well as others.

Another initiative to help enhance the competencies of C&A service providers is the provision of education and training in Evidenced Informed Practices and consultation to child and adolescent providers. A training initiative for mental health providers on working with children who have experienced trauma is currently being developed in collaboration with the Department of Children and Family Services. Training on WRAP for providers who work with teens is ongoing. There are three agencies piloting WRAP in Chicago, one in LaSalle, the forensic adolescent inpatient unit in Springfield, and a sixth agency in southeastern Illinois will be trained this year. These efforts are expected to continue during FY2009.

### **Disaster Response: Emergency Health Services**

As reported in Section II of this application, the Governor has designated the DMH as the lead State agency for disaster resource coordination, training and recovery functions related to mental health. Working in the collaborative context of the overall Statewide Disaster Plan, DMH is coordinating Illinois' disaster preparedness for state operated and state funded psychiatric service entities. See Section II, Adult and Child Plans.

# Illinois

## Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

### **Allocation Of Block Grant Dollars In FY2009**

The Illinois plan for the expenditure of the FY 2009 Community Mental Health Services Block Grant is directed at providing services in community settings for children and adolescents with serious emotional disturbances. The Illinois block grant fund amount for FY 2009, based on projections from FY 2008 is \$16,023,807. Please note however that the grant awards to community providers represent the best known information available as per their issuance in July of 2008. These projections are based on FY 2008 awards. The state budget as appropriated and approved reflects the FY 2009 level of award continuing to be provided. Administrative expenses, which are capped at 5%, amount to \$696,227 (slightly less than 5%). A table detailing allocation of dollars to agencies providing services to adults and children has been included in the appendix. Detailed information is also provided regarding the specific services purchased using block grant dollars.

### **Block Grant Allocation of dollars for Children's services**

For FY 2009, block grant funds will be directed toward the following community-based services for youths with serious emotional disturbances: psychiatric services, residential and crisis services. The child and adolescent funding allocation of mental health block grant dollars is consistent with the State Mental Health Plan for Children and Adolescents.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	35,270	37,773	38,000	38,500	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Increase access to services
- Target:** Serve an additional 500 children/adolescents in FY 2009.
- Population:** Children and adolescents with emotional and serious emotional disturbances
- Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services
- Indicator:** Number of child/adolescents receiving services from DMH-funded community-based providers.
- Measure:** Number of child/adolescents receiving services from DMH-funded community-based providers.
- Sources of Information:** ROCS System. This indicator is generated from URS Table 2A and 2B.
- Special Issues:**
- Significance:** Services should be accessible to children and adolescents with mental health needs.
- Action Plan:** DMH will continue to collect and track available data for FY 2009.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1.94	3.19	2	2	N/A	N/A
Numerator	2	3	--	--	--	--
Denominator	103	94	--	--	--	--

### Table Descriptors:

- Goal:** To encourage assurance of sufficient clinical stabilization of individuals released from the state hospital through planning and preparation of post-hospital community-based mental health services prior to being discharged.
- Target:** Maintain level of readmission rates of children and adolescents to state hospitals
- Population:** Children and adolescents with serious emotional disturbances.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Decreased rate of civil readmissions to state psychiatric hospitals within 30 days.
- Measure:** Numerator: Number of civil readmissions to any state hospital within 30 days  
Denominator: Number of civil discharges in the year.
- Sources of Information:** Inpatient Clinical Information System.
- Special Issues:**
- Significance:**
- Action Plan:** DMH will continue to monitor the number of Children and adolescents readmitted to state hospitals within 30 days of discharge with a FY 2009 goal of maintaining or decreasing the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	6.80	6.38	6	6	N/A	N/A
Numerator	7	6	--	--	--	--
Denominator	103	94	--	--	--	--

### Table Descriptors:

- Goal:** To encourage assurance of sufficient clinical stabilization of individual from the state hospital though planning and preparation of post-hospital community-based mental health services prior to being discharged.
- Target:** Maintain level of readmission rate to state hospitals
- Population:** Children and adolescents with serious emotional disturbances.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Decreased rate of civil readmissions to state psychiatric hospitals within 180 days.
- Measure:** Numerator: Number of civil readmissions to any state hospital within 180 days  
Denominator: Total number of civil discharges in the year.
- Sources of Information:** Inpatient Clinical Information System.
- Special Issues:**
- Significance:** Provision of treatment in the least restrictive setting
- Action Plan:** Data from FY 2006 serves as the baseline for this indicator. DMH will continue to monitor the number of Children and adolescents readmitted to state hospitals within 180 days of discharge with a FY 2009 goal of maintaining the level of re-hospitalization by maintaining services in the community that provide alternatives to re-hospitalization.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Therapeutic Foster Care  
(Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** Not Applicable. Illinois is not implementing this EBP.
- Target:** The DMH is not currently planning to implement therapeutic foster care.
- Population:** Children and adolescents with serious emotional disturbances.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of children and adolescents receiving therapeutic foster care
- Measure:** Number of children and adolescents receiving therapeutic foster care
- Sources of Information:**
- Special Issues:** Foster care is provided through the state welfare agency. The DMH does not anticipate that it will implement this EBP.
- Significance:**
- Action Plan:** The DMH has no current plans to implement therapeutic foster care as this service would be administered by the state child welfare agency.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** NOT APPLICABLE. DMH has no plans to implement multi-systemic family therapy in Illinois
- Target:** None. The DMH is not currently providing this EBP
- Population:** Children and adolescents requiring multi-systemic therapy
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of children/adolescents receiving multi-systemic therapy
- Measure:** Number of children/adolescents receiving multi-systemic therapy
- Sources of Information:**
- Special Issues:** The DMH is not currently implementing multi-systemic therapy. Rather it is focusing on evidence-informed practices.
- Significance:**
- Action Plan:** While multi-systemic therapy is practiced by a few child serving agencies, the DMH is not currently implementing multi-systemic therapy with children. DMH is focusing on evidence-informed practices (see Section III-A, objective C1.3)

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	N/A	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** NOT APPLICABLE. DMH has no plans to implement this EBP.
- Target:** None. the DMH is not currently implementing this EBP.
- Population:** Children and adolescents with serious emotional disturbances.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of children/adolescents receiving family functional therapy
- Measure:** Number of children/adolescents receiving family functional therapy
- Sources of Information:**
- Special Issues:** DMH is focusing on evidence informed practices and has no specific plans to implement family functional therapy at this time.
- Significance:**
- Action Plan:** The DMH has no plans at this time to implement family functional therapy as it is focusing its effort on evidence-informed practices.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	55.29	57	60	N/A	N/A
Numerator	0	277	--	--	--	--
Denominator	N/A	501	--	--	--	--

### Table Descriptors:

- Goal:** To assess the proportion of persons served by the DMH-funded community-based mental health service system that report positively about outcomes for children and adolescents receiving services.
- Target:** Increase by 3% the percentage of caregivers reporting positive outcomes for their children/adolescents receiving DMH funded mental health services.
- Population:** Parents/caregivers of children/adolescents receiving DMH funded mental health services.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percentage of caregivers reporting positive outcomes of treatment for their children/adolescents who receive mental health services.
- Measure:** Numerator: Number of caregivers reporting positively about outcomes of treatment  
Denominator: Total number of family responses regarding perception of outcomes
- Sources of Information:** Youth Services survey report from URS Table 11.
- Special Issues:**
- Significance:** Individuals receiving treatment should have positive outcomes for treatment.
- Action Plan:** DMH aims to increase the percentage of caregivers reporting positive outcomes for the Child and Adolescent services. The survey will be repeated in 2008.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	64	0	0	N/A	N/A
Numerator	N/A	48	--	--	--	--
Denominator	N/A	75	--	--	--	--

### Table Descriptors:

- Goal:** Improve school attendance of children/adolescents with serious emotional disturbances receiving mental health treatment
- Target:** No target specified due to low response rate and developmental nature of the indicator
- Population:** Children and adolescents with emotional and serious emotional disturbances.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent of parents reporting improvement in child's school attendance.
- Measure:** Derived from Table 19 URS  
Numerator: Number of parents reporting improvement in child's school attendance. (Both new and continuing clients).  
Denominator: Total responses (excluding not available) new and continuing clients combined
- Sources of Information:** None currently
- Special Issues:**
- Significance:** Children/adolescents with ED/SED should benefit from receiving mental health services
- Action Plan:** The DMH will collect this information through the MHSIP Youth Services Survey in FY 2008.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	0	33.33	0	0	N/A	N/A
Numerator	0	1	--	--	--	--
Denominator	N/A	3	--	--	--	--

### Table Descriptors:

- Goal:** Decreased Juvenile Justice Involvement for children/adolescent who have forensic issues and who are receiving mental health treatment
- Target:** Data for this indicator was collected in 2007, however due to the developmental nature of the measure and the low response rate we have elected not to set a target for 2008.
- Population:** Children/adolescents with serious emotional disturbances who are involved with the justice system and who are receiving mental health services
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent of children/youth consumers arrested in Year 1 who were not rearrested in Year 2.
- Measure:** Numerator: Number of children/youth consumers arrested in T1 who were not rearrested in T2 (new and continuing clients) Denominator: Number of children/youth consumers arrested in T1 (new and continuing clients combined).
- Sources of Information:** Not currently available
- Special Issues:**
- Significance:** The provision of mental health services should have an impact on the outcomes for children/adolescents involved in the justice system
- Action Plan:** The DMH will include the questions used to produce this indicator on the 2008 survey which will be collected by December 1, 2008. We are still evaluating the use of the MHSIP Youth Services Survey to capture information for this indicator.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1.14	.83	.83	.83	N/A	N/A
Numerator	365	295	--	--	--	--
Denominator	32,006	35,684	--	--	--	--

Table Descriptors:

- Goal:** Increase stability in housing by reducing number of children who are homeless or living in shelters
- Target:** Track percentage of children who are homeless or living in shelters. This data is collected at one point in time at intake prior to treatment. At the point in which T1 and T2 data is collected a target will be established.
- Population:** children/adolescents who are homeless or living in shelters
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent of Child/Adolescent clients who are homeless or living in shelters.
- Measure:** Numerator: Number of child/adolescent clients who are homeless or living in shelters.  
Denominator: All child adolescent clients with living situation excluding persons with Living Situation Not Available.
- Sources of Information:** ROCS--The indicator is produced from URS Table 15
- Special Issues:**
- Significance:**
- Action Plan:** Continue collecting this data and reporting it through the URS Tables.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	78.84	0	0	N/A	N/A
Numerator	N/A	395	--	--	--	--
Denominator	N/A	501	--	--	--	--

### Table Descriptors:

- Goal:** Increase consumers perception their social connectedness has improved as a result of participating in treatment.
- Target:** Developmental Measure - No target established
- Population:** Children/adolescents with serious emotional disturbances
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent of Families reporting positively about social connectedness.
- Measure:** Numerator: Number of families of child/adolescent consumers reporting positively about social connectedness.  
Denominator: Total number of family responses regarding social connectedness.
- Sources of Information:** Surveys were sent to caretakers of 3250 child and adolescent consumers (2765 valid addresses) receiving services in June 2007. 501 completed surveys (18%) were returned.
- Special Issues:**
- Significance:**
- Action Plan:** DMH will collect this data using the MHSIP Youth Services Survey in 2008 and continue working with the states, CMHS and NRI to further define.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	56.89	0	0	N/A	N/A
Numerator	N/A	285	--	--	--	--
Denominator	N/A	501	--	--	--	--

Table Descriptors:

- Goal:** Increase caregivers' perception of functioning as a result of treatment.
- Target:** No target established--no basis for establishing
- Population:** Children and adolescents with emotional/serious emotional disturbances
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations
- Indicator:** Percent of families reporting positively about functioning.
- Measure:** Numerator:Number of families of child/adolescent consumers reporting positively about functioning.  
Denominator: Total number of family responses regarding functioning.
- Sources of Information:** Surveys were sent to 3250 (2765 valid addresses) caretakers of child and adolescent consumers who were receiving services as of June 2007. 501 completed surveys were returned.
- Special Issues:**
- Significance:**
- Action Plan:** DMH will collect this measure again in 2008 using the Youth Services Survey.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

### Name of Performance Indicator: CASE MANAGEMENT-C & A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	14.90	15.77	15	15	N/A	N/A
Numerator	1,672	1,984	--	--	--	--
Denominator	11.23	12,579	--	--	--	--

### Table Descriptors:

- Goal:** To maintain case management services as a key core service to children with serious emotional disturbances being served in the DMH-funded community-based service system.
- Target:** Projected target is maintenance because the data source does not capture complete information. Also making changes to service matrix in FY 2008 and FY 2009.
- Population:** Children and adolescents with serious emotional disturbances
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Reporting of Community Services (RoCS).
- Measure:** Numerator: Children identified as members of the DMH “target” population being served by the DMH-funded community-based service system who receive case management services. Denominator: All children receiving DMH-funded community mental health services.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:** In prior fiscal years DMH funded agencies providing SASS services, which includes case management services as a key component, reported these services directly through the DMH community reporting system (ROCS). Several years ago, community providers began reporting services directly to the state Medicaid agency. As a result, we are unable to accurately determine the total number of children/adolescents receiving case management services because we do not have access to this data. This loss of data is reflected in the reported value of this performance indicator.
- Significance:** During FY 2005, 10,345 children in the DMH target population were reported in the DMH ROCS system as receiving services; of these individuals, only 15.3% are reported as having received case management services which is a gross underestimate. The DMH initiated efforts to re-acquire this data in FY 2006, but was unsuccessful; thus we do not anticipate that we will be able to fully report on this indicator, however we wish to continue monitoring this indicator.
- Action Plan:** DMH will retain this indicator, however, we anticipate that the information will continue to underrepresent the percent of children and adolescents receiving services.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

### Name of Performance Indicator: CORRECTIONS HISTORY - C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1.08	.92	1	1	N/A	N/A
Numerator	380	347	--	--	--	--
Denominator	35,104	37,773	--	--	--	--

#### Table Descriptors:

- Goal:** To track forensic status of children and adolescents served by the Illinois Mental Health system.
- Target:** Forensic population expected to remain relatively constant at approximately 1%.
- Population:** Children and Adolescents with serious emotional disturbances.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of children and adolescent clients reporting involvement with the Department of Corrections/Juvenile Justice at the time of case opening.
- Measure:** Numerator: Number of children and adolescents reported as Department of Corrections clients (e.g. probation, parole) at the time of case opening.  
Denominator: Total number of children and adolescents served in the fiscal year.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** Tracking this information helps to insure coordination of services between the mental health system and juvenile corrections.
- Action Plan:** Community mental health staff track the number of children and adolescents who are forensic outpatients (0.8%), as well as those who are on probation or parole (a little over 1%) at the time of case opening. This data is collected as part of clinical assessments. DMH will continue to track these percentages in FY 2009.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** Co-Occurring Disorders C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	1.15	1.05	1	1	N/A	N/A
Numerator	403	395	--	--	--	--
Denominator	35,104	37,773	--	--	--	--

### Table Descriptors:

- Goal:** To increase community-based mental health service for persons who have co-occurring disorders of mental illnesses and substance use.
- Target:** The target for this indicator is expected to remain at approximately 1%.
- Population:** Children and adolescents with serious emotional disturbances and co-occurring substance use disorders.
- Criterion:** 3:Children's Services
- Indicator:** Percentage of Child and Adolescents (C&A) served with a mental illness and substance use diagnosis.
- Measure:** Numerator: Number of clients served in the community with a substance abuse diagnosis.  
Denominator: Total number of all child and adolescents receiving services.
- Sources of Information:**
- Special Issues:** There is underreporting for this population because many mental health professionals prioritize mental health issues as principle treatment concern in reporting to the state mental health authority.
- Significance:** Many individuals with serious mental illnesses and emotional disturbances have co-occurring substance abuse disorders.
- Action Plan:** DMH will continue to track this information in FY 2009 with a goal of increasing the capacity for identification of dually diagnosed youth.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** ELIGIBLE POPULATION - C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	86.50	87.78	88	90	N/A	N/A
Numerator	30,353	33,158	--	--	--	--
Denominator	35,104	37,773	--	--	--	--

Table Descriptors:

- Goal:** To assure resources and services are provided to children and adolescents in the priority population of the public mental health system.
- Target:** Increase percentage of children and adolescents receiving mental health services who meet eligibility requirements.
- Population:** Children and adolescents with serious emotional disturbances
- Criterion:** 2:Mental Health System Data Epidemiology
- Indicator:** Percent of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.
- Measure:** Numerator: Number of children and adolescents being served by DMH-funded community-based providers who meet the established criteria for “eligible population” at the time of entry into services.  
Denominator: All children and adolescents being served by DMH-funded community-based providers.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** This indicator is part of the monitoring process to insure that mental health services are accessible and accessed by those who need them most.
- Action Plan:** DMH has a goal of increasing the proportion of children and adolescents served who meet the criteria for the eligible population.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

### Name of Performance Indicator: FORENSIC OUTPATIENT-C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	.80	.80	.80	.80	N/A	N/A
Numerator	280	303	--	--	--	--
Denominator	35,104	37,773	--	--	--	--

#### Table Descriptors:

- Goal:** To track forensic status of children and adolescents served by the Illinois mental health system
- Target:** Maintain the percent of children and adolescents with involvement in the juvenile justice system.
- Population:** Children and adolescents with serious emotional disturbances.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of children and adolescent clients who had been court ordered into treatment due to not guilty by reason of insanity, found unfit to stand trial, or by criminal court at the time of case opening.
- Measure:** Numerator: Number of children and adolescent clients reported as unfit to stand a trail, not guilty by reason of insanity, criminal, or directed for court ordered treatment at the time of case opening.  
Denominator: Total number of children and adolescents served in the fiscal year.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** The service needs of this small but high risk group require that assessment and adequate services are provided and tracked.
- Action Plan:** DMH will continue to track these percentages in FY 2009.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

### Name of Performance Indicator: LIVING ARRANGEMENTS-C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	92.90	93.82	93	93	N/A	N/A
Numerator	32,613	35,438	--	--	--	--
Denominator	35,104	37,773	--	--	--	--

#### Table Descriptors:

- Goal:** To track demographic information on living arrangements for child and adolescent clients.
- Target:** Maintain percentage of children and adolescents with mental emotional disturbances who live in private residences.
- Population:** Children and adolescents with mental illness.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of children and adolescent clients living with parents or other relatives in private residences at the time of case opening.
- Measure:** Numerator: Number of children and adolescents reported as living with parents or other relatives in private residence at the time of case opening.  
Denominator: Total number of children and adolescents served in the fiscal year with known living arrangements.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** Community mental health staff track living arrangements at intake for children and adolescents to assess service needs. At the time of case opening in FY 2007, the vast majority of children and adolescents lived with parents or other relatives in a private residence (93%). Nevertheless, services are needed to help those children who do not reside with their families.
- Action Plan:** DMH will track these percentages in FY 2009.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** RURAL RESIDENTS SERVED - C&A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	11,014	11,590	11,500	12,000	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

Table Descriptors:

- Goal:** To assure that children with emotional disturbances who reside in rural areas are accessing the DMH-funded community-based mental health service system.
- Target:** Increase the number of children/adolescents residing in rural areas by 500 using telepsychiatry and other strategies.
- Population:** Children and adolescents with emotional disturbances who live in rural areas of the state.
- Criterion:** 4:Targeted Services to Rural and Homeless Populations
- Indicator:** Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
- Measure:** Number of children being served by DMH-funded community-based providers who are residents of rural areas at the time of entry into services.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:**
- Significance:** The geography of rural areas adds challenges to the timely and consistent access to services for both service providers and persons with mental illness.
- Action Plan:** DMH aims to expand access to community mental health services for children and adolescents residing in rural areas.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

### Name of Performance Indicator: SASS SERVICE HOURS IN COMMUNITY

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	0	0	N/A	N/A
Numerator	N/A	N/A	--	--	--	--
Denominator	N/A	N/A	--	--	--	--

#### Table Descriptors:

- Goal:** To assure that a significant portion of services delivered within the SASS programs are provided in the most normalized settings possible in the individual's community, rather than within the provider's offices or clinics.
- Target:** A target is not set because the data source does not capture complete information at this point in time.
- Population:** Children and adolescents with serious emotional disturbances.
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems
- Indicator:** Percentage of children identified as members of the DMH "target" population being served by the DMH-funded community-based service system who receive SASS services.
- Measure:** Numerator: Number of hours of service provided by the DMH-funded SASS Programs which occur outside of the provider's offices or clinics.  
Denominator: Total number of hours of service provided by the DMH-funded SASS Programs.
- Sources of Information:** Reporting of Community Services (RoCS).
- Special Issues:** This data is no longer reported directly to the DMH. Data was not available for FY 2005, FY 2006, and FY 2007 and 2008. We will retain this indicator as a placeholder because of its importance. We hope to reacquire the information in FY 2009.
- Significance:** SASS programs aim to provide services in the most normalized settings possible in the individual's community, rather than within the provider's offices or clinics.
- Action Plan:** DMH is still working to retrieve this information and is retaining this indicator as a placeholder pending re-acquisition of this data as it is important to monitor delivery of these critical services.

## CHILD - GOALS TARGETS AND ACTION PLANS

**Transformation Activities:**

**Name of Performance Indicator:** TARGET POPULATION - C & A

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Projected	FY 2009 Target	FY 2010 Target	FY 2011 Target
Performance Indicator	32	33	35	37	N/A	N/A
Numerator	11,225	12,579	--	--	--	--
Denominator	35,104	37,773	--	--	--	--

Table Descriptors:

<b>Goal:</b>	To assure that resources and services are provided to children and adolescents in the priority population of the public mental health system.
<b>Target:</b>	To increase the percentage (by 2%) of child and adolescent mental health clients who have serious emotional disturbances receiving services.
<b>Population:</b>	Children and adolescents with serious emotional disturbances.
<b>Criterion:</b>	2:Mental Health System Data Epidemiology
<b>Indicator:</b>	Percentage of individuals being served by DMH-funded community-based providers who meet the established criteria for “target population” at the time of entry into services.
<b>Measure:</b>	Numerator: Number of children and adolescents being served by DMH-funded community-based providers that meet the established criteria for “target population” at the time of entry into services. Denominator: All children and adolescents being served by DMH-funded community-based providers.
<b>Sources of Information:</b>	Reporting of Community Services (RoCS).
<b>Special Issues:</b>	
<b>Significance:</b>	Children and adolescents with severe emotional disturbances (SED) are the priority target for mental health services.
<b>Action Plan:</b>	DMH aims to increase the proportion of children and adolescents served who meet the DMH criteria for the target population.

# Illinois

## Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

# ILLINOIS MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

Co-Chairs: Linda Denson  
Mark Heyrman

160 North LaSalle Street  
Suite S-1000  
Chicago, Illinois 60601  
Telephone: (312) 814-1115

August 29, 2008

Ms. Barbara Orlando  
Grants Management Specialist  
Division of Grants Management, OPS, SAMHSA  
One Choke Cherry Road, Room 7-1091  
Rockville, Maryland 20850

Re: Illinois Department of Human Services, Division of Mental Health Fiscal Year 2009 Block Grant Application

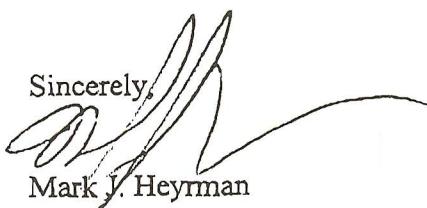
Dear Ms. Orlando:

I write on behalf of the Illinois Mental Health Planning and Advisory Council to express our enthusiastic support for the Illinois' 2009 Block Grant Application. Like many states, the Illinois has been badly hurt by the current economic recession and this has had a negative effect on the entire state budget including funding for mental health services. However, our Division of Mental Health has strong leadership under Director Lorrie S. Jones, Ph. D. and her talented administrative staff. They are working effectively to improve the delivery of mental health services in Illinois despite the difficult environment.

The Block Grant Application accurately describes important progress towards: (a) greater collaboration between the Division of Mental Health and the Illinois Department of Healthcare and Family Services; (b) new initiatives to divert persons with mental illness from the criminal justice system; (c) significant steps towards implementing the historic plan created by the Illinois Children's Mental Health Partnership; and, (d) greater involvement of consumers and peer specialists as part of Illinois' commitment to a recovery-focused model of mental health services. The Council strongly supports these initiatives.

The Council is also working to enhance its ability to fulfill its mission. Several years ago we moved from four to six meetings each year and restructured our committees. More recently the Division of Mental Health has increased its financial support for consumers to increase and improve their participation in the work of the Council. However, the Council's responsibilities under federal law are daunting. Director Jones has advised the Council that she is giving serious consideration to a formal written proposal from the Council to use Block Grant administrative funds to create a full-time, independent staff position to support our work. We believe that this is particularly necessary in order to enable us to be effective advocates for adequate state funding for mental health services as we are required to do under federal law.

In sum, we strongly support Illinois application for continued funding under this program.

Sincerely,  
  
Mark J. Heyrman

**Behavioral Health Services  
Portage-Cragin Counseling Center  
4840 W. Byron Street  
Chicago, Illinois 60641  
773.282.7800  
773.282.2163 Fax**

## Lutheran Social Services of Illinois

August 18, 2008

Linda Denson, Co-Chair  
Illinois Mental Health Planning and Advisory Council  
Sankofail Organization of Illinois  
P.O. Box 607294  
Richton, Illinois 60010

Mark Heyrman, Co-Chair  
Illinois Mental Health Planning and Advisory Council  
University of Chicago Law School  
1111 East 60<sup>th</sup> Street  
Chicago, Illinois 60637

Dear Ms. Denson and Mr. Heyrman:

As Chair of the Illinois Mental Health Planning and Advisory Council (IMHPAC) Planning Committee, I am writing this letter to endorse the Illinois 2009 Division of Mental Health Block Grant Application as well as to summarize the activity of the Planning Committee in this past year. Although the Block Grant Application is continuously under review, on July 10<sup>th</sup> and August 8<sup>nd</sup>, the Planning Committee completed a review of the following: the 2009 Block Grant Application, the FY 2008 achievements, and the FY 2008 performance and outcome indicators. As a result, the goals and objectives for the FY 2009 were also discussed and established.

One of the objectives for the FY 2009 is for the state of Illinois to further implement evidence-based practices (Supported Employment, Medication Algorithms, Integrated Dual Diagnosis Treatment, etc.). In addition, the state of Illinois would continue to promote consumer trainings (Regional Conferences, Wellness Recovery Action Plans, and Education and Support services).

One of the FY 2008 main achievements was to hold a retreat to increase awareness among IMHPAC members as to how we, as advocates, can advance the purpose of the Block Grant system and improve the mission and vision of the Illinois Division of Mental Health. This retreat took place on September 27<sup>th</sup>, 2007, in Springfield, Illinois. Overall, the retreat established the following four future areas of focus for IMHPAC:

- Accelerate Consumer Involvement
- Improve Council Function
- Establish IMHPAC as a Mental Health Authority

- Outreach/Access services for individuals (Limited English Proficiency, rural, multiple diagnoses/dual diagnoses, aging, etc.)

With regards to Improve Council Function, it became overwhelmingly apparent that IMHPAC needs to have a staff liaison to facilitate day to day operations and logistics for IMHPAC functions. The Planning Committee finds this position of critical importance to the future success of IMHPAC activities. IMHPAC unanimously agreed that administrative dollars, as allocated by CMHS/SAMSHA, should be used to support this position.

In addition, evaluation and data collection is also a major area of concern for IMHPAC. As such, the Planning Committee is in the process of making the necessary arrangements for developing a daylong workshop to help general IMHPAC membership better understand performance indicators and outcome measures used by Illinois in order to comply with the Block Grant system.

During the past year, the Planning Committee has continued to increase its role in working and collaborating with the Division of Mental Health in the development and monitoring of the Illinois Mental Health State Plan. With this in mind, the Planning Committee recommends your support of the Illinois 2009 Division of Mental Health Block Grant Application.

Sincerely,



Daniel B. Martinez, M.D.  
Chair, Planning Committee

# Illinois

## Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.

**TABLE 10****Illinois State Federal Block Grant Fund Awards - State Fiscal Year 2009**

<u>AGENCY NAME</u>	<u>ADDRESS</u>	<u>NAME OF DIRECTOR</u>	<u>PHONE#</u>	<u>AMOUNT OF BLOCK GRANT</u>
<b>MH ADULT BLOCK GRANT</b>				
ADAPT OF ILLINOIS INC 431613459	323 CONSORT DR BALLWIN MO	Sharon Hoffman, Controller	(636) 686-1304	\$1,726
ADVOCATE NORTHSIDE 363196629	836 W WELLINGTON CHICAGO IL	Heather Hutchison	0	\$318,338
ALEXIAN CENTER FOR MENTAL HLTH 363045007	3350 SALT CREEK LN STE 114 ARLINGTON HEIGHT IL	Denis Ferguson, Exec Director	(847) 952-7460	\$214,843
ASIAN HMN SVCS OF CHICAGO INC 363005889	4753 N BROADWAY STE 700 CHICAGO IL	Abha Pandya	(773) 728-2235	\$56,244
ASSOCIATION FOR INDIVIDUAL DEV 362472748	309 W NEW INDIAN TRAIL COURT AURORA IL	Lynn Oshea	(630) 844-5040	\$189,987
ASSOCIATION HOUSE OF CHICAGO 362166961	1116 N KEDZIE CHICAGO IL	Harriet Sadauskas, Exec Dir	(773) 772-7170	\$35,234
BEN GORDON CENTER 362771343	12 HEALTH SERVICES DR DEKALB IL	Michael Flora	(815) 756-4875	\$27,240
BOBBY E WRIGHT CCMHC 362775103	9 SOUTH KEDZIE AVE CHICAGO IL	Lucy Lang-Chappell	(773) 722-7900	\$401,709
BRIDGEWAY INC 370984175	2320 VETERANS DR GALESBURG IL	James Starnes	(309) 344-2323	\$153,581
CENTER ON DEAFNESS INC 237359883	3444 DUNDEE ROAD NORTHBROOK IL	Robert VanDyke	(847) 559-0110	\$2,805
CHESTNUT HEALTH SYSTEMS INC 370964629	1003 MARTIN LUTHER KING DR BLOOMINGTON IL	Alan Sender	(309) 827-6026	\$711,407
CHICAGO CITY OF 366005820	3510 S MICHIGAN CHICAGO IL	Larry Sachs	(312) 745-6071	\$135,669
CHICAGO CITY OF 366005820	333 S STATE ST RM 200 CHICAGO IL	Daryl Murphy, Grants Supvr	(312) 747-9826	\$135,669
CHRISTIAN CNTY MNTL HLTH ASSN 370951440	PO BOX 438 707 MCADAM DR TAYLORVILLE IL	Ralph Antle	(217) 824-9675	\$36,390
CIRCLE FAMILY CARE INC 362902782	5002 W MADISON CHICAGO IL	Reuben Pettiford, CEO	(773) 379-1000	\$61,971
COLES CO MENTAL HLTH ASSN INC 370864416	750 Broadway Avenue East MATTOON IL	Kathleen Roberts	(217) 238-5700	\$95,074
COMMUNITY CNSLNG CTRS CHICAGO 237115384	4753 N BROADWAY CHICAGO IL	ANTHONY KOPESA	(773) 769-0205	\$625,660
COMMUNITY COUNSELING CENTER OF 370798015	2615 EDWARDS ST ALTON IL	Karen Sopronyi	(618) 462-4883	\$59,759
COMMUNITY MENTAL HLTH CNCL INC 510137613	8704 S CONSTANCE AVE CHICAGO IL	CARL BELL, M.D.	(773) 734-4033	\$387,933

<u>AGENCY NAME</u>	<u>ADDRESS</u>	<u>NAME OF DIRECTOR</u>	<u>PHONE#</u>	<u>AMOUNT OF BLOCK GRANT</u>
COMMUNITY RESOURCE CENTER INC 370915481	101 S LOCUST ST CENTRALIA IL	Denise Daum	(618) 533-1391	\$80,378
COMMUNITY WORKSHOP & TRAINING 376057596	3215 N UNIVERSITY PEORIA IL	MICHAEL F GRANE, Controller	(309) 686-3304	\$13,816
COMPREHENSIVE MENTAL HEALTH 370760015	3911 STATE ST E ST LOUIS IL	Marsha Johnson	(618) 482-7330	\$136,854
CORNERSTONE SERVICES 362706578	777 JOYCE RD JOLIET IL	James Hogan	(815) 741-7080	\$14,050
COUNSELING CENTER OF LAKEVIEW 362743345	3225 N SHEFFIELD CHICAGO IL	Norman Groetzinger, Exec Dir	(773) 549-1102	\$185,051
COUNTY OF MCHENRY ILLINOIS 366006623	620 DAKOTA ST CRYSTAL LAKE IL	Sandy W. Lewis, Exec Dir	(815) 455-2828	\$1,460
COUNTY OF MONTGOMERY 376001661	11191 ILLINOIS RT185 POBOX 128 HILLSBORO IL	Mark D. Dugger	(217) 532-2001	\$19,126
COUNTY OF WILL 366006672	501 ELLA AVE JOLIET IL	James E. Zelico	(815) 727-8485	\$243,098
CROSSPOINT HUMAN SERVICES 371085771	210 AVENUE C DANVILLE IL	Thom Pollock	(217) 442-3200	\$30,472
DELTA CENTER INC 371295687	1400 COMMERCIAL AVE CAIRO IL	Frederica Garnett	(618) 734-2665	\$51,888
DOUGLAS COUNTY MENTAL HEALTH & 371068054	114 W HOUGHTON TUSCOLA IL	CAROL FRANCISCO-DAVIS	(217) 253-4731	\$17,324
DUPAGE COUNTY 366006553	111 N COUNTY FARM RD WHEATON IL	LELAND LEWIS	(630) 682-7400	\$375,978
ECKER CTR FOR MENTAL HLTH INC 362312495	1845 GRANDSTAND PL ELGIN IL	Karen Beyer	(847) 695-0484	\$335,672
EGYPTIAN PUBLIC & MENTAL 376006931	1412 US 45 N ELDORADO IL	Richard Patera	(618) 274-3326	\$50,096
EVANSTON NORTHWESTERN HEALTH 362167060	2650 RIDGE AVE EVANSTON IL	Ray Grady, Pres./CEO	(847) 570-2005	\$11,394
FAMILY COUNSELING CENTER INC 376147532	PO BOX 759 MARKET & WASHINGTON GOLCONDA IL	Larry W Mizell	(618) 683-2461	\$44,589
FAMILY SERVICE & CMNTY MENTAL 362428268	4100 VETERANS PARKWAY MCHENRY IL	Robert Martens	(815) 385-6400	\$627,028
FAMILY SERVICE & MENTAL HEALTH 362246705	5341 W CERMAK CICERO IL	John Morgan, Exec Director	(708) 656-6430	\$82,400
FAMILY SERVICE MENTAL HLTH CTR 362179793	120 S MARION ST OAK PARK IL	Dan Kill	(708) 383-7500	\$58,033
FRANKLIN-WILLIAMSON HUMAN 370916475	902 W MAIN ST WEST FRANKFORT IL	John Markley	(618) 937-6483	\$266,616
GATEWAY FOUNDATION INC 362670036	819 S WABASH AVE STE 300 CHICAGO IL	Michael Darcy	(312) 663-1130	\$22,954

<u>AGENCY NAME</u>	<u>ADDRESS</u>	<u>NAME OF DIRECTOR</u>	<u>PHONE#</u>	<u>AMOUNT OF BLOCK GRANT</u>
GRAND PRAIRIE SERVICES 362362364	17746 S OAK PARK AVE TINLEY PARK IL	Dennis Regnier	(708) 444-1012	\$231,669
HABILITATIVE SYSTEMS INC 362969062	415 S KILPATRICK CHICAGO IL	Donald Dew	(773) 261-2252	\$52,000
HEARTLAND HEALTH OUTREACH INC 363775696	4750 N SHERIDAN RD ST 300 CHICAGO IL	SID L. MOHN	(773) 506-2379	\$36,103
HEARTLAND HUMAN SERVICES 370912882	1200 N 4TH ST PO BOX 1047 EFFINGHAM IL	Cheryl Compton	(217) 347-7179	\$36,233
HELEN WHEELER CENTER FOR 362521946	275 E COURT ST STE 102 KANKAKEE IL	Marilyn Nichols	(815) 939-3543	\$126,975
HERITAGE BHVRL HEALTH CTR INC 370765549	P O BOX 710 DECATUR IL	Diana Knaebe	(217) 420-4702	\$495,613
HUMAN RESOURCES DEV INST INC 362894887	222 SO JEFFERSON SUITE 200 CHICAGO IL	TERRA THOMAS MD	(312) 441-9009	\$76,213
HUMAN SERVICE CENTER 371004882	PO BOX 1346 - 600 FAYETTE PEORIA IL	John Gilligan MD	(309) 671-8010	\$44,767
HUMAN SUPPORT SERVICES 370968305	988 N ILLINOIS RT 3 PO BOX 146 WATERLOO IL	James E. Poschell	(618) 939-8644	\$23,895
INDEPENDENCE CENTER 363542328	2025 WASHINGTON ST WAUKEGAN IL	Michael Pierce, Exec Director	(847) 360-1020	\$26,991
INSTITUTE FOR HUMAN RESOURCES 370982494	310 E TORRANCE P O BOX 768 PONTIAC IL	Joseph Ronaldson	(815) 844-6109	\$21,248
IROQUOIS MENTAL HEALTH CENTER 510245262	323 W MULBERRY ST PO BOX 322 WATSEKA IL	DENNIS HOPKINS	(815) 432-5241	\$15,028
JANE ADAMS CMNTY MNTL HLTH CTR 362879689	421 W EXCHANGE ST FREEPORT IL	Daniel E. Neal	(815) 599-7337	\$27,194
JANET WATTLES CENTER 362862928	526 W STATE ST ROCKFORD IL	Frank H. Ware	(815) 968-9300	\$154,789
JEFFERSON COUNTY COMPREHENSIVE 237254917	PO BOX 428 - ROUTE 37 NORTH MT VERNON IL	Jean Baumgarten	(618) 242-1511	\$59,898
JEWISH VOCATIONAL SERVICE AND 362167762	216 W JACKSON BLVD STE 700 CHICAGO IL	Alan Goldstein	(312) 673-3405	\$129,571
KENNETH YOUNG CENTER 237181444	1001 ROHLWING RD ELK GROVE VILLAG IL	Mitchell Bruski	(847) 529-8800	\$36,146
LAKE COUNTY 366006600	3012 GRAND AVE WAUKEGAN IL	Dale W. Galassie, Exec Dir	(847) 377-8073	\$40,060
LESTER AND ROSALIE ANIXTER CTR 362244895	6677 N LINCOLN AVE STE 400 LINCOLNWOOD IL	ALLAN I BERGMAN	(773) 973-7900	\$23,293
LEYDEN FAMILY SVCS & M H CTR 362235147	10001 W GRAND AVE FRANKLIN PARK IL	Dennis Vaccaro	(847) 451-0330	\$93,882
LOCUST STREET RESOURCE CENTER 370983795	320 SOUTH LOCUST STREET CARLINVILLE IL	Doug Kilberg	(217) 854-3166	\$66,971

<u>AGENCY NAME</u>	<u>ADDRESS</u>	<u>NAME OF DIRECTOR</u>	<u>PHONE#</u>	<u>AMOUNT OF BLOCK GRANT</u>
LORETO HOSPITAL 362200248	645 S CENTRAL CHICAGO IL	STEVE DRUCKER, CEO	(773) 854-5000	\$64,480
LUTHERAN SOCIAL SERVICES OF IL 362584799	1001 E TOUHY AVE SUITE 50 DES PLAINES IL	SUSAN GREGORY	(847) 635-4600	\$84,456
MAINE CENTER INC 362616713	819 BUSSE HWY PARK RIDGE IL	FRANCES HOOK HUME, CEO	(847) 696-1570	\$19,730
MASSAC COUNTY MENTAL HEALTH 371011136	206 W 5TH ST METROPOLIS IL	Dr. Yvonne Rath, Exec Dir	(618) 524-9368	\$9,723
MCLEAN COUNTY CTR HUMAN SRV IN 370673455	108 W MARKET ST BLOOMINGTON IL	Tom Barr	(309) 827-5351	\$97,695
MENTAL HEALTH CENTER OF 370913985	1801 FOX DRIVE CHAMPAIGN IL	Sheila Ferguson, Exec Director	(217) 398-8080	\$97,098
MENTAL HEALTH CENTERS OF 370920535	700 SE CROSS ST MT STERLING IL	Sean Eifert, Exec Director	(217) 773-3325	\$62,394
MENTAL HEALTH CTRS OF CNTRL IL 370646367	710 N 8TH ST SPRINGFIELD IL	BRIAN ALLEN	(217) 525-1064	\$139,923
METROPOLITAN FAMILY SERVICES 362167940	1 N DEARBORN STE 1000 CHICAGO IL	Richard Jones	(312) 986-4224	\$117,348
MOUNT SINAI HOSP MEDICAL CTR 361509000	CALIFORNIA AVE AT 15TH ST CHICAGO IL	David Wilson	(773) 257-5315	\$414,999
NORTH CENTRAL BEHAVIORAL 362645920	PO BOX 1488 LASALLE IL	DONALD MISKOWIEC	(815) 434-4727	\$151,918
NORTHPOINTE RESOURCES INC 362409058	3441 SHERIDAN RD ZION IL	COLLEEN BABINGTON	(847) 872-1700	\$26,925
NORTHWESTERN MEMORIAL HOSPITAL 370960170	446 E ONTARIO 7TH FL CHICAGO IL	MARGE SONDLER, Mgr. Psychi <i>atn:</i>	(312) 926-8744	\$492,318
OCCUPATIONAL DEVELOPMENT CTR 370899934	1201 E BELL STE A BLOOMINGTON IL	Matt Jackson, Vice Pres	(309) 820-0723	\$11,535
PILLARS COMMUNITY SERVICES 364166490	6918 W WINDSOR AVE BERWYN IL	Mary Stecher	(708) 788-0511	\$95,173
PILSEN-LITTLE VILLAGE MENTAL 362836998	2319 S DAMEN ST CHICAGO IL	FRANCISCO CISNEROS	(773) 579-0832	\$139,781
PROVISO FAMILY SERVICES INC 362709982	1414 MAIN ST MELROSE PARK IL	J MELVIN SMITH	(708) 338-3806	\$108,489
ROBERT YOUNG CENTER FOR 363678909	2701 17TH ST ROCK ISLAND IL	Doris Crowe, Adm Asst	(309) 779-2043	\$97,517
SAINT MARY & ELIZABETH MED CTR 362171079	2233 W DIVISION CHICAGO IL	Margaret McDermott	(312) 770-2606	\$53,773
SERTOMA CENTRE INC 362720586	4343 W 123RD ST ALSIP IL	Gus Van Den Brink, Exec. Dir.	(708) 371-9700	\$27,746
SINNISIPPI CENTERS INC 362596200	325 ILLINOIS ROUTE 2 DIXON IL	James R. Sarver	(815) 284-6611	\$80,697

<u>AGENCY NAME</u>	<u>ADDRESS</u>	<u>NAME OF DIRECTOR</u>	<u>PHONE#</u>	<u>AMOUNT OF BLOCK GRANT</u>
SOUTHEASTERN IL COUNSELING 371095903	504 MICAH DRIVE POBOX DRAWER M OLNEY IL	GARY ROBERT	(618) 395-4306	\$137,329
SOUTHERN IL REGIONAL SOCIAL 370795898	604 E COLLEGE ST CARBONDALE IL	KAREN FREITAG	(618) 457-6703	\$92,432
STEPPING STONES OF ROCKFORD IN 362693681	706 N MAIN ST ROCKFORD IL	Stephen Langley	(815) 963-0683	\$17,488
TAZWOOD MENTAL HEALTH CTR INC 371278969	1423 VALLE VISTA BLVD PEKIN IL	Ralph T. Brower	(309) 347-5579	\$114,083
THE THRESHOLDS 362518901	4101 N RAVENSWOOD AVE CHICAGO IL	Miki Badgot	(773) 572-5219	\$197,316
TRANSITIONS NFP 363153563	PO BOX 4238 ROCK ISLAND IL	Gary Weinstein, CEO	(309) 283-1206	\$68,843
TRANSITIONS OF WESTERN IL INC 370971282	4409 MAINE ST PO BOX 3646 QUINCY IL	Michael Rein	(217) 224-2194	\$72,450
TRI-COUNTY COUNSELING CENTER 370995131	220 E COUNTY RD PO BOX 381 JERSEYVILLE IL	Carol Schaffner	(618) 498-9587	\$31,767
TRILOGY INC 362795409	1400 W GREENLEAF CHICAGO IL	Jim Graham	(773) 508-6100	\$125,220
TRINITY SERVICES INC 362194838	100 N GOUGAR RD JOLIET IL	Art Dykstra, Exec Dir	(815) 485-6197	\$33,577
UNION CNTY COUNSELING SVCS INC 370970953	204 SOUTH ST PO BOX 548 ANNA IL	Mary McMahan	(618) 833-8551	\$18,149
VICTOR C NEUMANN ASSOCIATION 362407164	5547 N RAVENSWOOD CHICAGO IL	Tina Fogarty	(773) 769-4313	\$88,853

Sum of **22876440A**

**\$11,529,280**

<u>AGENCY NAME</u>	<u>ADDRESS</u>	<u>NAME OF DIRECTOR</u>	<u>PHONE#</u>	<u>AMOUNT OF BLOCK GRANT</u>
<b>MH C&amp;A BLOCK GRANT</b>				
ADVOCATE NORTHSIDE 363196629	836 W WELLINGTON CHICAGO IL	Heather Hutchison	0	\$54,064
ALEXIAN CENTER FOR MENTAL HLTH 363045007	3350 SALT CREEK LN STE 114 ARLINGTON HEIGHT IL	Denis Ferguson, Exec Director	(847) 952-7460	\$50,966
ASIAN HMN SVCS OF CHICAGO INC 363005889	4753 N BROADWAY STE 700 CHICAGO IL	Abha Pandya	(773) 728-2235	\$109,333
ASSOCIATION HOUSE OF CHICAGO 362166961	1116 N KEDZIE CHICAGO IL	Harriet Sadauskas, Exec Dir	(773) 772-7170	\$125,182
BRIDGEWAY INC 370984175	2320 VETERANS DR GALESBURG IL	James Starnes	(309) 344-2323	\$605,014
CENTER FOR CHILDRENS SERVICES 370716057	702 N LOGAN AVE DANVILLE IL	David Coleman MD	(217) 446-1300	\$36,526
CHILDRENS HOME ASSOCIATION OF 370662601	2130 N KNOXVILLE PEORIA IL	ARLENE HAPPACH	(309) 685-1047	\$55,539
CIRCLE FAMILY CARE INC 362902782	5002 W MADISON CHICAGO IL	Reuben Pettiford, CEO	(773) 379-1000	\$109,249
COMMUNITY MENTAL HLTH CNCL INC 510137613	8704 S CONSTANCE AVE CHICAGO IL	CARL BELL, M.D.	(773) 734-4033	\$55,179
COMPREHENSIVE MENTAL HEALTH 370760015	3911 STATE ST E ST LOUIS IL	Marsha Johnson	(618) 482-7330	\$31,914
DE PAUL UNIVERSITY 362167048	2219 N KENMORE CHICAGO IL	Rafaela E. Weffer	(773) 325-7780	\$27,891
DELTA CENTER INC 371295687	1400 COMMERCIAL AVE CAIRO IL	Frederica Garnett	(618) 734-2665	\$13,529
ECKER CTR FOR MENTAL HLTH INC 362312495	1845 GRANDSTAND PL ELGIN IL	Karen Beyer	(847) 695-0484	\$51,032
EGYPTIAN PUBLIC & MENTAL 376006931	1412 US 45 N ELDORADO IL	Richard Patera	(618) 274-3326	\$13,529
FAMILY COUNSELING CENTER INC 376147532	PO BOX 759 MARKET & WASHINGTON GOLCONDA IL	Larry W Mizell	(618) 683-2461	\$13,529
FAMILY SERVICE ASSOCIATION OF 362169149	22 S SPRING ELGIN IL	Lisa LaForge, Exec Director	(847) 695-3680	\$52,191
GATEWAY FOUNDATION INC 362670036	819 S WABASH AVE STE 300 CHICAGO IL	Michael Darcy	(312) 663-1130	\$10,862
GRAND PRAIRIE SERVICES 362362364	17746 S OAK PARK AVE TINLEY PARK IL	Dennis Regnier	(708) 444-1012	\$361,440
HEARTLAND HUMAN SERVICES 370912882	1200 N 4TH ST PO BOX 1047 EFFINGHAM IL	Cheryl Compton	(217) 347-7179	\$16,550
HELEN WHEELER CENTER FOR 362521946	275 E COURT ST STE 102 KANKAKEE IL	Marilyn Nichols	(815) 939-3543	\$108,934

<u>AGENCY NAME</u>	<u>ADDRESS</u>		<u>NAME OF DIRECTOR</u>	<u>PHONE#</u>	<u>AMOUNT OF BLOCK GRANT</u>
HEPHZIBAH CHILDRENS HOME ASSN 362167096	946 NORTH BLVD OAK PARK	IL	Mary K. Tortorici, Fin Dir	(708) 445-5685	\$11,388
HERITAGE BHVRL HEALTH CTR INC 370765549	P O BOX 710 DECATUR	IL	Diana Knaebe	(217) 420-4702	\$31,119
JANET WATTLES CENTER 362862928	526 W STATE ST ROCKFORD	IL	Frank H. Ware	(815) 968-9300	\$512,847
LAKE COUNTY 366006600	3012 GRAND AVE WAUKEGAN	IL	Dale W. Galassie, Exec Dir	(847) 377-8073	\$50,862
LOCUST STREET RESOURCE CENTER 370983795	320 SOUTH LOCUST STREET CARLINVILLE	IL	Doug Kilberg	(217) 854-3166	\$16,582
MCLEAN COUNTY CTR HUMAN SRV IN 370673455	108 W MARKET ST BLOOMINGTON	IL	Tom Barr	(309) 827-5351	\$7,887
MENTAL HEALTH CTRS OF CNTRL IL 370646367	710 N 8TH ST SPRINGFIELD	IL	BRIAN ALLEN	(217) 525-1064	\$15,841
METROPOLITAN FAMILY SERVICES 362167940	1 N DEARBORN STE 1000 CHICAGO	IL	Richard Jones	(312) 986-4224	\$109,239
PILLARS COMMUNITY SERVICES 364166490	6918 W WINDSOR AVE BERWYN	IL	Mary Stecher	(708) 788-0511	\$109,187
ROBERT YOUNG CENTER FOR 363678909	2701 17TH ST ROCK ISLAND	IL	Doris Crowe, Adm Asst	(309) 779-2043	\$628,145
SINNISIPPI CENTERS INC 362596200	325 ILLINOIS ROUTE 2 DIXON	IL	James R. Sarver	(815) 284-6611	\$79,154
THE THRESHOLDS 362518901	4101 N RAVENSWOOD AVE CHICAGO	IL	Miki Badgot	(773) 572-5219	\$287,183
WILPOWER INC 363555018	444 W FRONTAGE RD NORTHFIELD	IL	Susan Shimon	(847) 501-2939	\$36,413

Sum of **22876440B**

**\$3,798,300**

<u>AGENCY NAME</u>	<u>ADDRESS</u>	<u>NAME OF DIRECTOR</u>	<u>PHONE#</u>	<u>AMOUNT OF BLOCK GRANT</u>
			<b>Grand Total</b>	<b><u>\$15,327,580</u></b>